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LEGISLATION RELATING TO VA MENTAL HEALTH PROGRAMS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED FIRST CONGRESS

FIRST SESSION

ON

S. 13 (Sections 201-204), Amendment No. 124 to S. 13, S. 86, S. 192, S. 405, and S. 846

JUNE 14, 1989

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LEGISLATION RELATING TO VA MENTAL HEALTH PROGRAMS

WEDNESDAY, JUNE 14, 1989

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The committee met, pursuant to notice, at 9 a.m., in room SR-418, Russell Senate Office Building, Hon. Alan Cranston (chairman of the committee) presiding.

Present: Senators Cranston and Murkowski.

OPENING STATEMENT OF CHAIRMAN CRANSTON

Chairman CRANSTON. The hearing will please come to order. I welcome you all to this morning's hearing.

What we are concerned about today is legislation relating to Department of Veterans Affairs mental health programs. Although VA plays a vital role in providing psychiatric care to veterans, a large percentage of whom are service connected, it is an area that has too often been neglected. It is my intent, as demonstrated by this committee's continued interest in this area, that VA end that neglect and bring to bear the resources necessary to provide quality mental health care.

I have a detailed written statement, which is on the press table, describing the bills we will be addressing today and expressing many concerns about the subjects covered.

Section 221 of S. 13 concerning security at VA health-care facilities was originally scheduled for oral testimony today, but instead will be discussed at our hearing next week in order to gain testimony on these matters from VA's Deputy Secretary. We will be asking VA to provide us with a thorough description of its security program by early next week.

One area about which I continue to be very concerned and most dissatisfied is VA programs for PTSD treatment. The RTI report data indicate, and I believe this is a very alarming statistic, that almost 20 years after the vast majority of our troops left Vietnam 829,000 of the 3.14 million Vietnam veterans are currently suffering from PTSD or PTSD symptoms. Even more significantly, the RTI data indicate that only 10 percent of those almost half a million veterans with full-blown cases of PTSD have seen a mental health professional on at least one occasion, and of those it remains unknown how many actually pursued any real course of treatment.

Currently, VA has only 16 specialized inpatient PTSD units, with four new units to be added in fiscal year 1990. Currently, all of these specialized units have a waiting list for admission to treatment, ranging from several weeks at Menlo Park to 1 year at American Lake. In addition, the majority of these inpatient units have waiting lists for admission into screening programs in which veterans are admitted for a few days, accessed, discharged, and if deemed appropriate, then put on a second waiting list for admission. These screening waiting lists range from a week at Coatesville to 32 weeks at American Lake. This means that veterans with PTSD in the American Lake region must generally wait a total of 20 months, almost 2 years, to get needed treatment. Given that many clinicians see the special inpatient units as providing intensive care to patients in acute need of treatment, these waiting lists present a tremendous inadequacy in VA's ability to meet its top priority responsibility, the provision of quality care in a timely way to veterans suffering from service-related disabilities.

In addition, I understand that VA will shortly be designating PTSD clinical teams to specialize in PTSD treatment at 23 of its 172 medical centers. Eight of these PTSD clinical teams will be created by utilizing a portion of the additional $5 million I was successful in getting appropriated for PTSD treatment in fiscal year 1989. It's regrettable that these teams will not be in place until so late this fiscal year.

VA is also planning on using a portion of the $5 million to create four PTSD substance use disorder programs, one of which has been designated at the Menlo Park facility which, typically for it, has been conducting a pilot program of this nature for the last year. Often, PTSD sufferers also abuse drugs and alcohol in their attempts to dull their psychological pain by "self-medicating" themselves.

These modest treatment efforts are laudable, but they are totally inadequate in the face of the enormous unmet needs of veterans with combat-related PTSD. Moreover, these VA actions come only after Congress took the initiative in adding the $5 million, of which VA has diverted over 40 percent for other than direct PTSD treatment. I believe VA has been generally slow and unresponsive in carrying out its responsibilities as to PTSD.

It's all well and good for the Department to devise novel programs to address chronic mental illness and to stimulate congressional interest in innovative therapies in conjunction with CWT, which we will address this morning. But VA's major mission is to deal with service-related conditions, and its medical leadership has never displayed the sensitivity to this mission that I believe is called for, especially in the case of the PTSD treatment needs so dramatically illustrated by the RTI report. These shocking and highly disturbing RTI data have been available to VA for almost a year now. Yet the VA still has not made available to the committee, despite persistent requests for it, a plan to deal with the tremendous unmet need for treatment on the part of almost a half million Vietnam veterans with full-blown PTSD right now. What we hear over and over from VA's medical leaders is let us study the problem more.

The time for study is past and the time for action on the PTSD front is now. I look forward to the witnesses' testimony on the PTSD provisions.

Now, with regard to the CST provisions, I note with great interest the action of The American Legion in Pittsburgh, and the keen interest expressed by the Disabled American Veterans in its testimony, in becoming actively involved in setting up such nonprofit corporations. I look forward to their testimony and the other testimony on these provisions.

On the HCMI program, although quite successful as homeless programs go, I believe the program's 25 percent success rate suggests questions about cost effectiveness in this time of such scarce and strained resources, especially when VA mental health leaders are agitating for legislation to promote other experimental promising therapies, while VA's basic efforts to treat PTSD, as well as its overall low priority for mental health efforts, falls so short of the mark. Hence, I will be asking the General Accounting Office to conduct a review of the HCMI program.

Finally, my prepared statement includes some remarks about the mortality study data released yesterday by VA. I'll be pursuing some questions this morning about that study, especially the very high rates of likely problem deaths on general medical and surgical wards at six VA largely psychiatric hospitals. I also am requesting GAO to initiate a review of VA's actions pertaining to the study in order to determine if the methodology to be used for followup is appropriate, and then to follow VA's action to determine if the followup is completed as described, if the actions taken as a result of the followup are proper, and if GAO would recommend that other actions be taken.

Again, I welcome all the witnesses this morning. I thank you all for your assistance and timely submission of your prepared statements, all of which will be printed in the record in full.

We have a prepared opening statement from Senator Matsunaga, who's bill, S. 192 is among those before us this morning. His statement will appear in the record.

[The prepared statement of Senator Matsunaga appears on p. 111.]

Chairman **Cranston**. Before proceeding with our first witnesses, I want to note that since we have many witnesses today, we ask each witness to limit his or her oral testimony to 5 minutes, so that we will have sufficient time for questions. We'll be using the lights here this morning. When you see the yellow light, you have 1 minute remaining on your time. When you see the red light and hear the bell your 5 minutes have expired, so then please conclude your remarks.

We've asked all witnesses for prepared statements, which will, of course, be printed in full in the hearing record. We've received, or will be receiving testimony from the American Psychiatric Association, and the American Psychological Association.

Now, we'd like to welcome Dr. John Gronvall, VA's Chief Medical Director; Dr. Paul Errera, Director of the Mental Health and Behavioral Sciences Service; Dr. Art Blank, Director of the Readjustment Counseling Service; and Ralph Ibson, Deputy Assistant General Counsel.

I thank you all for being here this morning. John, as you know, we'd appreciate you keeping your oral statement to 5 minutes.

[The prepared statement of Chairman Cranston appears on p. 94.]

STATEMENT OF DR. JOHN A. GRONVALL, CHIEF MEDICAL DIRECTOR, DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY DR. PAUL ERRERA, DIRECTOR, MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICE; DR. ARTHUR S. BLANK, DIRECTOR, READJUSTMENT COUNSELING SERVICE; AND RALPH J. IBSON, DEPUTY ASSISTANT GENERAL COUNSEL

Dr. **Gronvall**. Thank you, Mr. Chairman. I believe I can cover it very briefly, and I appreciate your advance introduction of the people here at the table, and the statement that our full written statement will be included in the record.

So with that, I will just comment very briefly, first on S. 405 and section 3 of S. 846, which would extend authorization for our homeless chronic mentally ill program. We do believe this has been a successful program. We've submitted two reports to the Congress of evaluation of the program. We prefer that the reauthorization be for 5 years rather than 3 years to reduce some of the programmatic uncertainty in that program, which we believe has been a demonstrated success.

Both your amendment to S. 13, and the bill, S. 846 would broaden our authority for compensated work therapy programs. Again, we believe those programs have been shown to be effective in providing a therapeutic work experience for patients with both physical and mental health problems. Both of these bills would facilitate development and operation of therapeutic residences, although we believe that your amendment to S. 13 contains very helpful concepts, our statement gives a number of reasons why, on balance, we believe S. 846 provides the VA with a greater degree of flexibility to design workable programs, so we support enactment of that bill.

As your opening statement noted, there are several proposals on today's agenda regarding PTSD, and I'll comment briefly on each. First, section 201 of S. 13 would direct us to provide hospital care and outpatient treatment on a priority basis to all veterans with a diagnosis of post-traumatic stress disorder. From our perspective, we have been taking steps to expand availability of care for PTSD. I should note that just within the past week we have, in fact, identified and assigned the 23 additional PTSD clinical treatment teams that you referred to in your opening statement.

We believe that the separation between medical diagnosis and adjudication of service connectedness needs to be preserved as a separate function of Veterans Benefits Administration, and so we oppose legislation that would, on a statutory basis, provide priority of care on the basis of a particular diagnosis, and we look forward to commenting further on that.

Section 202 would continue the statutory basis of the special committee on PTSD. We feel that that provision is not necessary. We do intend to continue the committee. It has been useful to us, and we continue to have it in operation and to seek its advice. We strongly oppose the requirement that the committee report concurrently to the Secretary of Veterans Affairs, and to the Congress. We think that undermines the role of the committee as an advisor to the VA. So we strongly resist the erosion of the Secretary's authority that that provision contains.

And then, finally, section 203 of S. 13, and the bill, S. 192, would require an additional study among Asian Americans, American Indian, Native Hawaiian, and other Native American Pacific Island, and Alaska Native veterans. We believe that the data in the recent study conducted by Research Triangle Institute, and other studies give enough basic data to serve the needs of program planning, so we do not believe additional studies need to be done.

And then section 204 would require, in essence, a special budgetary submission for post-traumatic stress disorder to project on a budgetary basis funding, work load, and other activities. Our budget, and our appropriation request is not structured on the basis of individual diagnosis. The background data from past activities are not readily available, and we believe that to comply with this requirement would require the creation of whole new record systems and entail costs that we think should better be directly supportive of medical care programs.

Our statement gives the reasons why we oppose legislation to reorganize the security system, but we have no further comment on that today, and look forward to the subsequent hearing where that will be discussed.

Mr. Chairman, that concludes my summary, and we'll be pleased to respond to questions. And I am pleased that I finished within the time limit. Thank you.

[The prepared statement of Dr. Gronvall appears on p. 117.]

Chairman CRANSTON. Yes, I'm pleased also.

John, in a May 10, 1989 letter, Secretary Derwinski informed the committee that the Advisory Committee on the readjustment problems of Vietnam veterans was renewed for only 1 year. In the past this Advisory Committee has received 2-year authorizations. In view of the RTI data showing that such a tremendous number of veterans with readjustment problems have not received assistance, I don't understand the shorter term. Could you explain why the extension of time was reduced to 1 year, especially in light of the RTI finding?

Dr. GRONVALL. Mr. Chairman, of course, the Secretary would be the only one that could directly speak to that, but in the discussion we had when that decision was made, I think it's appropriate to say that somewhat similar decisions were made in a number of other areas. A new administration was assuming responsibility for the VA, with an overall desire to review all of our management activities, committee structures, and a feeling that preserving flexibility to make a review and then, if necessary, make adjustments either in management structures or advisory committee structures, would be appropriate. And I believe it was on that general basis rather than any specific concern focused on that committee. But, again, the Secretary should respond directly to that question, I think.

Chairman CRANSTON. Did VHS&RA recommend a longer extension?

Dr. GRONVALL. Yes, we had recommended a longer extension.

Chairman CRANSTON. How long?

Dr. GRONVALL. We had recommended a 2-year extension.

Chairman CRANSTON. I'd appreciate your expressing my concerns about this to Secretary Derwinski, and I'd appreciate it if you would ask him on my behalf to reassess that 1-year reduction. And could you report back on that next week?

Dr. **Gronvall**. We will certainly do so.

Chairman **Cranston**. As I'm sure you're aware, John, psychiatry services are having an extremely difficult time recruiting qualified psychiatrists. For instance, a recent field study of 160 VA medical centers conducted by the Mental Health and Behavioral Sciences Service, found that there are 29 full-time Chief of Psychiatry vacancies, 189 full-time staff vacancies, and 50 part-time staff vacancies. Can you tell me why psychiatry has not been designated as a scarce specialty for special pay purposes?

Dr. **Gronvall**. The pay structure for physicians that we utilize is based on comparative information obtained from academic medical centers, private sector medical community. Our present pay arrangements have been in place for some time. We have, by statute, the possibility to reassess that whole matter on a periodic basis. The last report we had developed on physician pay, several years ago, unfortunately was completed during the year that the entire Federal Government was subjected to an across-the-board pay freeze so no adjustments were made.

We, by we I mean the VHS&RA, recently completed the current proposal on physician pay. We made a comprehensive set of recommendations to the Secretary. The report is being reviewed by the Secretary and his staff. And so we expect action shortly, and a set of new proposals to update all of our physician pay and special pay provisions based on the most current information we have. Psychiatry is not the only category where our pay has not kept pace with the competitive market, and it is correct that psychiatry is not, at the current time, I believe, appropriately recognized in our pay provisions, as is the case with a number of other disciplines. And we hope to correct that through the study that is now pending for final action.

Chairman **Cranston**. Will you review the need for such a designation, however, and let me know your decision by the end of the month?

Dr. **Gronvall**. I surely will, and I don't know whether Dr. Errera has any additional comments. He speaks to me often about the difficulties of recruiting psychiatrists, and he may want to add a comment.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

During preparation of the VA's Quadrennial Report on Physicians and Dentists Pay a comprehensive review of compensation for VA psychiatrists was undertaken. The report addresses special pay as but one component of a set of comprehensive recommendations. As Dr. Errera indicated during the hearing, we are making our pay recommendations as a component of this report and have not separately addressed scarce specialty pay designation for psychiatry.

Dr. **Errera**. I think, as Dr. Gronvall said, the response, hopefully, is in the quadrennial pay report that's pending now.

Chairman **Cranston**. Have you recommended that a special pay designation be made?

Dr. **Errera**. I was a member of that committee, and I was told that we shouldn't discuss the contents of the report, but I certainly presented the problems being experienced by psychiatry in VA to that committee.

Chairman **Cranston**. Do you personally favor this special pay designation?

Dr. **Errera**. The report is more comprehensive than special pay, and looks at longevity and a number of other factors. I'm in favor of changing the pay structure, and there are a number of very constructive suggestions, I think, that are being proposed in the new recommendations.

Chairman **Cranston**. Well, have you made any recommendations to the Chief Medical Officer on your own, apart from that commission study?

Dr. **Errera**. I was able to make all of my recommendations in the committee setting.

Chairman **Cranston**. What is your view, should there be special pay, or should there not be?

Dr. **Errera**. I think there should be higher pay, sir. The whole pay structure should be revamped. The pay schedule must recognize longevity of service to help us with retention of staff. Also, levels of responsibility in addition to scarce medical pay are the kinds of issues that are being looked at.

Chairman **Cranston**. What's the current status of the quadrennial special pay report that would address this issue? It was supposed to be made available December 31. What's holding it up?

Dr. **Gronvall**. That's really the report that we've been describing, of course. What held it up was that late last year we recognized that a whole additional year's worth of comparable data, particularly from academic medical centers, would be available, and so it was decided to wait a brief amount of time to have the study be based on much more current data. So the study was delayed. It has now been completed, and as I said earlier, is being reviewed by the Secretary.

Chairman **Cranston**. I understand that a new weighted work unit is currently being developed, which will give psychiatry an even lower reimbursement for care than under the RAM which a 1980 GAO study found already to be problematic. And according to PVA's testimony today, which cites a National Institute of Mental Health study, 51 percent of all veterans in need of mental health services receive that care through VA. From VA testimony at our June 16, 1988 hearing, we know that 48 percent of those who are service connected, clearly VA has vital responsibility in this area. But first, do you have any quarrel with that 51 percent figure?

Dr. **Gronvall**. I don't believe I have the data at my fingertips to comment on it, or quarrel with it. I don't know whether anyone else does. Dr. Errera?

Dr. **Errera**. That's NIMH data, and it's quite good, sir.

Chairman **Cranston**. What?

Dr. **Errera**. It is good data.

Chairman **Cranston**. What's the comparable figure for the provision of care to all general medical and surgical veteran patients that VA treats?

Dr. **Gronvall**. I don't, again, have an answer to that at my fingertips. I think we'd have to try to see whether we have a comparable figure that we could supply for the record.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Based on data from the 1987 Survey of Veterans (SOV) III, which was collected from a nationwide household interview sample survey of approximately 10,000 veterans, VA provided 46.6 percent of total psychiatric care (both inpatient and outpatient). For medical and surgical care provided by the VA (both inpatient and outpatient) the comparable percentage was 5.9.

Chairman **Cranston**. Would you please review the adequacy of the RAM reimbursement formula being planned for psychiatric services, and report back to us by June 28, if possible?

Dr. **Gronvall**. Yes.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The fiscal year 1990 RAM was run using the three models of inpatient, outpatient, and long term care with the same policies and assumptions in effect as for the fiscal year 1989 RAM. However, there was a technical modification relative to your concern, a refinement to the inpatient RAM costing methodology. A technical advisory group, composed of field clinical personnel judged that the assigned weighted work units for surgical DRGs understated the true VA costs of these cases. By using VA known operating room cost experience for surgical procedures in lieu of fiscal year 1981 medicare data, the weighted work unit value of surgical DRGs was increased, thereby resolving a persistent undervaluing of surgical weighted work load.

The relative work values for medicine and psychiatry did not change. The correction of surgical DRG weights resulted in an increase in the relative work value for surgery and for total relative work. With a fixed dollar pool, the allocation rate per weighted work unit declined. Since medicine and psychiatry received no additional credit for work, the allocations to these bed sections declined along with the lower allocation rate. When the "recosted" DRG surgical weights were run for the fiscal year 1990 RAM, surgery's relative position changed from a loss of $66.9 million in the fiscal year 1989 RAM to a loss of $27.3 million in the fiscal year 1990 RAM. Medicine's position changed from a gain of $19.2 million to a loss of $1 million. The impact on the psychiatry bed section was a change in their relative position from a gain of $42.8 million to a lesser gain of $25.1 million. These results pertain to national summaries; at the facility level the relative position will vary according to that facility's overall performance.

It should be noted however, that the RAM allocates funding to the total facility and is not based on programs within the facility. While the RAM funding adjustment is made as a centrally directed adjustment to a facility's recurring funding base, the distribution of the total RAM dollars to various programs within a facility is left to the discretion of the local VA medical center director in accordance with local priorities and procedures. In the past 3 years, while psychiatry has continued to be a relative RAM gainer, in fact, the proportion of dollars assigned to the program by the medical centers has declined. Therefore, it is difficult to accurately assess the potential impact of this technical modification on psychiatry or any of the other inpatient bed sections.

A development effort is currently underway to introduce new elements into RAM. These new elements are expected to more accurately delineate resource consumption patterns for individual patient types. This will add increased accuracy in assigning relative weights to patients such as those using long term psychiatric services.

Chairman **Cranston**. John, regarding the CWT proposals contained in S. 846, you state on page 7 of VA's written testimony, "that you could expect that STRAF funds, as well as private donations and rental payments, would be adequate to purchase outright the number of houses needed for this program."

It was my understanding based on recent briefings that committee staff has received from your staff, that STRAF funds and donations from private sources would definitely not be adequate for this purpose. Could you tell me upon what information your expectation that such funds would be adequate is based?

Dr. **Gronvall**. I think our proposal, of course, is to implement a pilot project, and so the projection that we've made here would be the constraints, or the framework, within which we would undertake this as a pilot project. I'm aware of the valid expression of concern made within the VA and elsewhere about whether those funds would be adequate or not. But we've reviewed the matter again, just recently, and believe it is appropriate to undertake the pilot within that constraint, and then that would be one of measures as to whether the approach of the pilot is appropriate or not. And if it turned out the funds were not available adequately over time from that source, then we would have new evidence on the basis of experience rather than advance projection on which to base a different recommendation.

Dr. Errera, I don't know if you want to add.

Chairman **Cranston**. Yes, Dr. Errera, do you have any views to express on the adequacy of the funds?

Dr. **Errera**. Yes, Mr. Chairman.

We're proposing a demonstration project. And we feel there is enough money between the STRAF account and the grants and gifts that we would get for the demonstration project. The intent is to evaluate the effectiveness of this suggested approach, compared to other approaches, for some of the homeless chronically, mentally ill veterans. If it turns out that it is as good as we think it will be, and more cost effective, then we would come back to Congress and ask if we could use some of our existing HCMI funds that are now used for contracts, a sum which is over $9 million, and use some of that money to develop therapeutic residences.

Chairman **Cranston**. What is the amount of extra STRAF dollars that exist, and how much STRAF money are you talking about spending for each CWT TR program?

Dr. **Errera**. The STRAF is a revolving fund. Right now in the account as of April 30, 1989, there was $1.4 million, and we have spent $1.5 million this year. The feeling is that there will be enough money to help buy the few houses in addition to what we receive from grants and gifts.

Chairman **Cranston**. Would a reliance on current STRAF receipts for these purposes result in a reduction of other CWT efforts?

Dr. **Errera**. No, it wouldn't. We recently started a national fund within the STRAF revolving fund whereby we've asked all of the CWT programs to contribute 1 percent of their gross. The intent of this move was to have startup money to do just this kind of thing, or other worthwhile projects.

Chairman **Cranston**. On pages 7 and 8 of VA's written testimony, you state that operation of the program outlined in S. 846 would not increase costs. Given that S. 846 would expand the VA's mission into the direct operation of community based therapeutic residences, requiring the purchases of residential property, furnishings, insurance, maintenance, utilities and the hiring of a resident manager, I'm curious how you arrived at that conclusion. How much money would VA expect to receive from donations from nonprofit corporations, which under S. 846 are to operate as conduits for funding?

Dr. ERRERA. Let me remind you that this is a limited demonstration project, and we're saying that for the small number of sites to be selected we do have the funds. If it turns out that this is a good project, then, as I mentioned, we would be asking Congress at a later time for permission to shift some of our available HCMI moneys.

Chairman CRANSTON. What additional funds would be tapped, or could be, if costs of this program exceed available STRAF funds?

Dr. ERRERA. In your proposal, you talk about the general post fund. Our initial intent was to have grants, gifts, and STRAF for the demonstration project.

We also are going to be doing this in places where it won't cost us money to get the houses because we'll be using available VA space. To do that, however, we need permission to charge rent.

Chairman CRANSTON. How much STRAF money would you propose to spend on a pilot program over each of the next 3 years?

Dr. ERRERA. Let me put it this way, when The American Legion was kind enough to buy four houses for us in Pittsburgh recently—they spent $20,000 for four rowhouses. My assumption is that we would be spending under $100,000.

Chairman CRANSTON. Is that about $100,000 a year?

Dr. ERRERA. I am not as good a business person as I am a physician, and Mrs. Joan Sheldon maybe could, in a written response give you the specifics on this?

Chairman CRANSTON. How can we find out if STRAF funds are adequate if you don't really know how much you're going to be spending?

Dr. ERRERA. It depends on the contents of the requests for proposals that come back. For example: is it a rural or urban area; are the potential houses inexpensive or expensive; how much money we'll be able to generate through grants, how many would be nonprofit homes, and how many would be available. All in all, I'd say $100,000 at this point.

Chairman CRANSTON. I think we should get a written response on this.

Dr. GRONVALL. We'd be pleased to, Mr. Chairman. I would just comment again that one of the reasons for proposing this as a pilot is that while it's possible to make projections on some of those figures, until you actually try it, you don't know how close your projections are. And so I think that's the reasons why you're hearing some unease about the accuracy of any such projections until we actually get into the market and try it.

[Subsequently, the Department of Veterans Affairs furnished the information which appears on p. 138.]

Chairman CRANSTON. Page 12 of your testimony suggests that the nonprofit model proposed in my legislation would deplete STRAF funds even though my amendment provides that the 25 percent of purchase price loan be repaid to the STRAF, allows for transfer of general post funds into the STRAF and specifically directs that 50 percent of all profits earned by a nonprofit from a sale of a therapeutic residence, be turned over to the STRAF. Could you please explain your concern about this so-called depletion of STRAF under my legislation, as contrasted with a STRAF depletion that would occur under S. 846 which you support, and which would use STRAF funds for the purchase and maintenance of property, including furnishings, insurance, maintenance, utilities, and the hiring of a resident manager, and all other expenses involved in direct VA operation of the therapeutic residence?

Dr. ERRERA. The overhead costs of running the nonprofits just based on the experience that we've had with the existing nonprofits, is significantly higher than the cost of running CWT programs which we control directly. These additional costs reflect the expenses of insurance, liability, and the personnel that are hired, all of which result in overhead costs that are markedly higher.

Whereas, a VA operated program would not have to absorb these special expenses.

Chairman CRANSTON. It's hard to understand how when you don't know how much it's going to cost VA, how you know that it would cost more for a nonprofit——

Dr. ERRERA. Our experience with nonprofits such as at Menlo Park shows the high overhead costs of nonproifts.

Chairman CRANSTON. Do you have a number of how much more it's really going to cost with the nonprofit?

Dr. ERRERA. I don't know how much more. I know that it's more in terms of the overhead of running a nonprofit.

Chairman CRANSTON. Frank, I'd be glad to yield to you at this point.

OPENING STATEMENT OF SENATOR MURKOWSKI

Senator MURKOWSKI. I apologize for being late, Mr. Chairman.

The provision contained in S. 846, relating to VA's compensated work therapy program is a very important piece of legislation. We have a few witnesses here testifying, for the most part, in support of this bill. I have a rather lengthy statement, but I won't delay the process, and would ask that it be entered in the record at this time. I suggest we proceed.

[The prepared statement of Senator Murkowski appears on p. 113.]

Chairman CRANSTON. Do you have any questions?

Senator MURKOWSKI. I have a few.

The proposal from my colleague, Senator Cranston, on compensated work therapy, requires that the program be run by a nonprofit corporation where the bill, S. 846, keeps the operational control of the program under VA. Your preference, I assume, is keeping it under the VA. What is the advantage or disadvantage of this?

Dr. GRONVALL. Dr. Errera.

Dr. ERRERA. Our preference is for the flexibility of S. 846, which gives us a choice either to put it under the VA or in a nonprofit, depending on the resources available in each community.

Senator MURKOWSKI. Now, Senator Cranston's proposal mandates nonprofit, and you prefer the flexibility.

Dr. ERRERA. Yes.

Senator MURKOWSKI. Well, I suppose it's a case of perception, whether we should mandate, or whether you should have the flexibility. From the standpoint of management, it's obviously beneficial to have that flexibility. So your position is you would want the choice?

Dr. ERRERA. We'd like the choice because we think that there are parts of the country, especially the rural parts, where housing is hard to get, as well as parts of the country where there isn't the kind of VA leadership or interest in the community to help create a nonprofit that will be functional. For example, in Knoxville, IA, we don't think we could get a nonprofit going but we could get the other program initiated.

Senator MURKOWSKI. I assume then, you're saying my bill gives you the opportunity to be flexible. What would you do in the case that you just outlined if you were mandated that CWT be run by a nonprofit corporation?

Dr. ERRERA. It would mean the choice of sites would be different. We hope to send out a "request for proposals," and if we are limited to nonprofits then we will receive only proposals from those parts of the country where nonprofits can be created, where the resources and the leadership is available to implement such a program.

Senator MURKOWSKI. And the other areas where they are not?

Dr. ERRERA. We'll then evaluate what we're doing and then come back to Congress with the recommendation to either stay with the nonprofits which are good for everybody, or, depending on our findings, come back and ask again for the option of diversification.

I think what makes Menlo Park unique is it's leadership, the richness of its community. It's a very special place which has not, interestingly, been duplicated in part. Dr. Graeber, the Chief of Staff at Menlo Park, is a very remarkable person with very unique talents.

Senator MURKOWSKI. So, you're suggesting there are areas that couldn't get the commitment of the community?

Dr. ERRERA. Yes.

Senator MURKOWSKI. The incentive just wouldn't be there.

Dr. ERRERA. There wouldn't be the interest, there wouldn't be the interest from the community, maybe not even from the local service organizations. The VA personnel might not have the charisma that's necessary to go and approach people and get them mobilized for this kind of project. But they still may be very good clinicians; they just may not have the breadth of talents of a Dr. Graeber.

Senator MURKOWSKI. Let me ask you about the 45 or so existing work compensation therapy programs. Are they adequate as structured?

Dr. ERRERA. They are working very well. They're one of our most effective programs. This has been documented by GAO and other reviews. It's a very good program.

Senator MURKOWSKI. As far as the cost of the two proposals, what is your estimate of the cost of our bill, as opposed to the position of Senator Cranston's legislation?

Dr. ERRERA. My assumption is that there will be no cost increment in either case.

May I go back and answer Senator Cranston's question as to why it costs more in a nonprofit. I have some figures here. The overhead for Menlo Park was $459,880. The overhead for all of our other CWT programs ranged from zero dollars to a high in one program of $50,000. That program is in Northampton and the cost relates to our having to rent space. But with most of our programs, the overhead is $10,000 to $20,000. So the difference between that and $500,000, or $460,000 is very significant. That's why we think that the nonprofits would be more expensive. We agree that in some parts of the country they may be what we have to do and would be the most effective.

Senator **MURKOWSKI**. VA recommends modification of our legislation (S. 846) to reflect a pilot program of 25 sites. As currently drafted, could VA implement the provision as a pilot program?

Dr. **ERRERA**. Yes, sir.

Dr. **GRONVALL**. Yes, sir.

Senator **MURKOWSKI**. So, no difficulty there.

There's a provision of the bill which would authorize VA to transfer funds provided for the homeless chronically mentally ill program, which is up to $5 million, to the Special Therapeutic and Rehabilitation Activity Fund to purchase houses to be used as therapeutic residences. How much money is currently in the fund?

Dr. **ERRERA**. There is right now, $1.4 million in the fund, but a lot of that money is already obligated to pay salaries, or for buying raw materials.

Senator **MURKOWSKI**. When you go in and make these acquisitions to provide therapeutic residence or other special uses, what type of procedures do you go through with local authorities on zoning and other things?

Dr. **ERRERA**. We work very carefully with the community, and very carefully with all of its elements of it—the unions, the churches, the bankers—and other concerned community leaders.

Senator **MURKOWSKI**. How about the zoning and applications of permitting, and all that paraphernalia?

Dr. **ERRERA**. The zoning, interestingly, is less of a problem for us because there are no staff that live in these facilities. So, in a way, these are a little bit like the "Oxford Houses" where they've shown that the house is a place where people who are not related to each other choose to live together. The house manager is not a VA employee, so the zoning will be easier. But there still will be community feelings that have to be recognized and dealt with.

Senator **MURKOWSKI**. If you go into a neighborhood and want to provide some of these facilities, do you have to get a variance?

Dr. **ERRERA**. No, we don't have to get a variance, as long as there's no staff living in the house. It's just a place like a house next to a college where a group of graduate students who are not related live together. However, there may be places where the feelings of the neighbors are so strong, that it will be clear it wouldn't be wise to proceed. That's why one of the things we asked for was permission to sell the house. In such a case, we would buy a house, do renovation work on it through the CWT program which would provide veterans with work and skill acquisition opportunities and then if it turns out that we should not keep the house in that community, we would sell it and the money would go back into the STRAF.

Senator **MURKOWSKI**. Do you know how much of your expenditures will actually go into the physical acquisition or cleanup, or whatever else you might have to do to adjust the residence to make it adequate?

Dr. **Errera**. Our hope is that we would get HUD grants to do that.

Senator **Murkowski**. I'm glad you mentioned HUD.

Dr. **Errera**. HUD is giving money just for that purpose, and we would be bidding for those grants very aggressively. We explored this very tentatively with HUD people during the Reagan administration, and they were very interested.

Senator **Murkowski**. Mr. Chairman, I'd like to have VA provide us with some figures, because I don't know why it came up, but it came up yesterday at a Republican caucus, of all things, a little bit about the HUD programs. It happened to focus on one of the counties in California. The indication was that there are approximately 125 permits that have to be obtained for HUD housing. 75 percent of the total cost of a HUD project actually is in the time associated with the drafting, revisions, and all of the bureaucratic paraphernalia associated with obtaining the actual permits. What we're saying here is that 75 percent of the cost is associated with preparing the paraphernalia of preparation, permitting, and so forth. The indication was it's like this all over the country. I would encourage VA to make sure that the dollars that are being spent in this area are for the actual, physical units and not to the extent that we're seeing in some of the HUD programs where three-quarters of the funding are lost on the bureaucracy.

Dr. **Errera**. Senator, I think this is more true when you're building—when HUD is building new houses. For the renovation, I think there may still be problems, but it's a smaller percent. But we will be alert to that.

Senator **Murkowski**. I have no further questions, Mr. Chairman.

Senator Thurmond regrets that he cannot be here. He has a statement for the record.

Chairman **Cranston**. Fine. That will appear in the record.

[The prepared statement of Senator Thurmond appears on p. 116.]

Chairman **Cranston**. John, would you please provide a detailed cost comparison of a CWT-TR program conducted under S. 846, and one conducted under my amendment, showing your best estimate of the total cost of the operation and the sources of the funding? And could we please have that by next Friday, June 23?

Dr. **Gronvall**. We'll certainly make every possible effort. I think we can comply with that date. We'll make a major effort.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

At this time, we anticipate implementing the proposed CWT-TR pilot program through the "request for proposal" process. We would explain the parameters of the law to field facility officials and then ask that they submit proposals for development of a program at their facility. We would anticipate significant variation among the proposals depending on the ingenuity of the persons preparing the proposals, and the resources they would have at their disposal. The amount that could be spent would depend on the resources available in each local STRAF account, and the amount that could be raised from contributions. The amount of contributions would, of course, vary depending on how adept the local facility is at raising money. Costs would also vary widely depending on the location of the facility. It is reasonable to expect the projects to be significantly more expensive in urban areas simply because housing is so much more expensive in urban areas. Costs would also vary depending on the size of facility to be acquired and the number of veterans it would serve. Unit actual proposals are obtained, we are unable to project the costs of running a facility under either bill.

Chairman **Cranston**. Thank you.

John, the therapeutic residence provisions proposed in S. 846, which you have supported except for funding transfer positions, would require the Secretary to prescribe in regulations the qualifications for and the fees for the services of house managers, but provides that the house managers would not be considered employees of the United States for any purpose. Who then would be the employer of the house manager?

Dr. **Errera**. The house manager would be a retired veteran, or maybe a couple where the husband or the wife is a retired veteran.

Chairman **Cranston**. Who would be the employer?

Dr. **Errera**. The STRAF account would provide the money to pay for that person. Now, I don't know the answer to your question, Senator, whether if the STRAF account pays—I could get an answer for you for that.

Chairman **Cranston**. Well, wouldn't the VA be the employer?

Dr. **Gronvall**. I don't think we would view it as an employment relationship, Mr. Chairman.

Dr. **Errera**. It's a contract.

Chairman **Cranston**. To whom would the house manager report?

Dr. **Errera**. The house manager would be working very closely with our CWT workers, who would be coming to the house during the day and working with them.

Chairman **Cranston**. Mr. Ibson, are you completely satisfied, both from a legal standpoint, and in terms of the Department's obligation to veteran patients that such a non-Federal employee arrangement fulfills VA's responsibilities?

Mr. **Ibson**. As a general matter, I'm confident that the concept is a satisfactory one. I think a lot more thought will be given in the process of developing and implementing a pilot program under Dr. Errera to giving it flesh and assure that those responsibilities are met.

Dr. **Gronvall**. If I may, Mr. Chairman, surely the contract that's established has as one of its major purposes to assure that the program meets the needs of veterans and the accountability needs and responsibility requirements of the VA.

Chairman **Cranston**. If not a Federal employee, the house manager would, I assume, receive no fringe benefits such as Federal health benefits, FECA protection in case of work injuries, EEO protection, due process protection for adverse action, labor representation if desired, and so forth. Am I correct in that, Mr. Ibson?

Mr. **Ibson**. I would say on a preliminary basis I think that's probably right.

Chairman **Cranston**. Well, do you want to think about it and give us a written response?

Mr. **Ibson**. That would be a safer answer.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

It is the Department's view that as an independent contractor, the house manager would not receive any of the benefits of Federal employment.

Chairman **Cranston**. John, do you believe that you will get many qualified persons to want to work under those conditions?

Dr. **Gronvall**. I think the question will have to be answered on the basis of experience. I believe a lot of creative thought and planning in advance has gone into this program proposal, and we wouldn't propose doing it if we didn't think it could be successful. If we knew we couldn't get people to work and the program wasn't going to work, we wouldn't propose it. So the answer is, yes, we believe it is workable.

Chairman **Cranston**. Why do you prefer this kind of non-Federal employee status of relationship?

Dr. **Gronvall**. Dr. Errera, I think, can answer that better.

Dr. **Errera**. I think of two reasons—one in terms of controlling costs, and two, in terms of the zoning question that Senator Murkowski raised. By not having a VA staff employee living in the house it creates a whole set of different conditions, which makes it more acceptable for zoning purposes. Again, let me go back to the Oxford house model, which is working very effectively and which has no live-in professional staff.

I would like to add that in the public and in the private sector this model has been tested and works. In my State of Connecticut, in the private sector the Institute of Living has done this in Hartford, and in the public sector the Fairfield Hills State Hospital has done the same thing—they own apartments or houses in the community.

Chairman **Cranston**. Is this just a way of getting around local zoning?

Dr. **Errera**. No, that is not the primary purpose. It is an unexpected side benefit. Let me put this in a broader context. American medicine is going to shift from its major focus on bed-based services toward ambulatory care, home services, community based services. Within the next 20 years much more of the care provided will be of this kind. If a sick person doesn't have a place to live in the community then we will provide some structural living arrangement in the community. For example, we could do this if we had the appropriate support structures for some chronic schizophrenics who spend much time in hospitals. I see this very much as a direction that medical care is going to be taking in the next 20 years. What we are requesting fits very well with this thrust. It's been done in other places, but it hasn't been talked about sufficiently yet.

Chairman **Cranston**. What you're proposing is not so much medical care as a residential solution to a problem, is it not?

Dr. **Errera**. No. This is medical care, sir. The residential solution is what the Oxford house does. That's the long-term permanent housing. This is structured therapeutic housing for time limited periods where you feel that the person can benefit from the supervised and structured attention that he will be getting, or she will be getting.

Chairman **Cranston**. Well, who's going to be in the house that's qualified to give medical care?

Dr. **Errera**. The medical care is going to be provided during the day to the degree that they'll be all in CWT programs, and they will be attending clinics or day programs. The degree of autonomy that they have by being alone in the house at night with a house manager, who will be a kind of colleague, is an important part of the reentry facet. There comes a point where the person has to be on their own in the community, but not quite on their own. So this is part of the transition in the direction of reentry into the community.

From a medical point of view this makes a lot of sense. The Boston, MA mental health center has written about this and shown how this works well.

Chairman **CRANSTON**. Well, my concern is about an entity that seems to be Federal, but doesn't have a Federal person in charge there.

Dr. **ERRERA**. That is a concern that my Director had, at West Haven, 20 years ago, when I first suggested that one of the wards not have a staff person on at night. We used it as a reentry community ward. We tried it and over the 15 years that we did it, there were no problems. It is the taking of a supervised first step. The choice is do we want to keep people in hospitals indefinitely, or do we want to help them go back to the community? If you help them go back to the community, you are taking a certain level of risk. The professionals in the programs have to determine who can succeed in this program and who can't. And most of the time, hopefully, we'll be correct in our predictions.

Chairman **CRANSTON**. Dr. Errera, S. 846 appears to authorize nonprofit corporations solely as a funding conduit, yet you seem to be suggesting the nonprofits under S. 846 actually run the CWT-TR programs. Would you clarify that discrepancy?

Dr. **ERRERA**. The CWT program is not run by the nonprofit. The CWT program is run by the VA as it is now. The nonprofit is for the running of the therapeutic residences in those places where we think it's indicated. That is my understanding of S. 846.

Chairman **CRANSTON**. That doesn't seem to conform to the way the bill is written, but that's your intention in any case?

Dr. **ERRERA**. Yes.

Chairman **CRANSTON**. On the National Center on PTSD, I was delighted to hear on May 11, 1989, that a new National Center on PTSD had been designated. I believe there's every reason to anticipate the White River Junction Consortium will be highly successful as a National Center. Very talented people are certainly involved, but only as long as it receives adequate funding. For fiscal year 1984, the Cleveland National Center was funded at $1.4 million per year. I understand the current plans call for funding the new National Center Consortium at $1.46 million for fiscal year 1989, even though several months ago in response to my prehearing budget question 70(b), you stated that $1.8 million of the $5 million, especially appropriated for PTSD treatment for fiscal year 1989, would be used to fund the National Center. Would you explain to me the discrepancy between the $1.8 million which earlier you planned to use for the National Center, and the $1.46 million now being allocated to the National Center, as well as what has happened to the remaining $340,000?

Dr. **ERRERA**. We were very happy to have gotten Cleveland to give up $1.4 million and give it back to us. That was a major accomplishment. It took us several years to make this transition. The $1.4 million was always the amount that we were talking about in terms of the annualized amount. I think what you're referring to is startup moneys, which this year we have been able to provide out of the $5 million because of the delay in being able to start the other programs. But there's been no change, that I'm aware of. There is about $1.8 million worth of startup funds that's being given to the National Center for this year. That's equipment and structural changes, things like that.

Chairman CRANSTON. How much is startup and how much is operating?

Dr. ERRERA. The $1.4 million is for personnel, and $1.8 million is what we've given for startup.

Chairman CRANSTON. And that's been allocated, the $1.8 million?

Dr. ERRERA. It's on its way.

Chairman CRANSTON. Frank, I have to leave briefly, and then I will return. If you don't have questions for these witnesses, we could have them wait. I do have some more questions and you could proceed with the next witnesses.

Senator MURKOWSKI. I have a couple of questions.

Chairman CRANSTON. Then you ought to proceed in that way. But if you want to proceed with other witnesses, after these witnesses, do that, and then I'll get back as fast I can. I'll be back fairly quickly.

But I would ask you to remain because I have some more questions.

Senator MURKOWSKI. I have a few more questions, gentlemen.

As you know, Senator Cranston and I have both introduced the legislation which would extend VA's authority to provide community-based halfway house treatment to homeless chronically mentally ill veterans. I don't know how VA employees view this type of program, but it's not a permanent program, is that right?

Dr. ERRERA. That's right, sir.

Senator MURKOWSKI. And the reason it's not permanent is?

Dr. ERRERA. We were authorized and funded on a year by year basis.

Senator MURKOWSKI. So how does the job security aspect fit in? Do you move those VA employees in there temporarily, with the understanding that they've got a permanent spot, or do they feel somewhat insecure in these positions?

Dr. ERRERA. The latter. Some VA medical centers have moved permanent employees in there, and made other employees in the medical center temporary. But about 20 percent of our employees are temporary, and we have a significant turnover which creates a problem, because continuity is really very important in this program.

Senator MURKOWSKI. How do you handle it, as best you can?

Dr. ERRERA. With difficulty, yes, sir.

Dr. GRONVALL. If I may, Mr. Chairman, the experience here is not unique in the VA. We've had a number of other programs in the past, that get started on this basis, and I think taking a broad view when starting a new program where there's question about what the effectiveness is going to be, it's understandable that it gets put on a temporary basis. It's true that that complicates the implementation of the program, but again, I think in a broad view that's often more desirable than making a permanent open-ended commitment to the program and the staff. If it then turns out that the program is not desirable, it's a much more difficult problem.

Our past experience in other areas is that as such programs get established, evaluated, when they are finally judged to be fully successful, and appropriate as permanent parts of the system, then the staff get converted to permanent positions and the program takes on a permanency.

Senator **MURKOWSKI**. There's no way within the VA you can move people through it to give them a sense of permanency, with the understanding that they're going to be in this program as part of, I don't know whether it be training, or familiarity, and then they move on.

Dr. **GRONVALL**. The answer is yes, we can do that, and Dr. Errera commented that in a number of the programs, permanent staff from the medical centers have been working in these programs, and they know that they can go back to the medical centers. So, we have done that to some extent.

Senator **MURKOWSKI**. Is there anything we can do to help you, or should we just leave you alone and let you figure it out yourself?

Dr. **ERRERA**. I think you have, in your proposal by recommending to extend it for 5 years. Now, the directors, very realistically, are concerned but they are going to be left all of a sudden with personnel for which they have no funds. Having a long-term program gives them the reassurance they need.

Senator **MURKOWSKI**. You don't have any assurances that this thing is going to be resolved in 3 or 4 years?

Dr. **GRONVALL**. Well, let me clarify a little bit, Mr. Chairman. The bills that have been introduced, I think reestablish the program, or extend it for 3 years. Our statement recommends that it be a 5-year authorization.

Senator **MURKOWSKI**. Our bill is 5 years.

Dr. **GRONVALL**. And we prefer the 5-year authorization, largely for that reason. The program has been evaluated. We have submitted two reports so far to the Congress. We believe it's demonstrated it's early success, and ought to have a longer authorization lifespan that will assist in the sense that it's going to be around for a longer period of time.

Senator **MURKOWSKI**. Is there anything other than increased pay that would attract more people into this area?

Dr. **GRONVALL**. Dr. Errera should speak to that.

Dr. **ERRERA**. I think the success of our program and the evaluation and the publication of the evaluation findings is creating a sense of a national program, which is having an impact, in the non-VA sector. I think that over the next few years we will be contributing to the rest of the homeless problem in the Nation by our ability to point out that certain therapeutic approaches are more effective or less effective with specific populations.

Senator Cranston pointed out, that we were successful in 25 percent of the cases. I think the figure is 50 percent. It's still not enough. But we'll be able to identify which groups it helps more and which groups it helps less. That, I think, will be of value to the Nation.

Senator **MURKOWSKI**. Senate bill 13 includes a provision which creates entitlement for PTSD treatment for veterans who have not been found under VA's adjudicatory process to be service connected. I gather you're opposed to this provision which would provide for this entitlement?

Dr. **GRONVALL**. That's correct.

Senator **MURKOWSKI**. The Disabled American Veterans also have expressed concern about that provisions recommending instead a memorandum rating to be accomplished for veterans, so that they receive priority treatment, while retaining the integrity of the adjudication process. What do you think of the DAV's recommendation?

Dr. **GRONVALL**. I think that's a recommendation that we should have a chance to review and comment on. The rating process and the adjudication process is not part of my responsibility. Our statement makes the strong position that that separation of medical diagnosis and treatment, which I am responsible for, and adjudication, which I'm not, be preserved. So, I think that suggestion should be reviewed by the VA and a comment made on it.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

> We recommend support of the DAV position on memorandum ratings. The use of memorandum ratings is appropriate for granting service connection for PTSD. We support VBA development of each case so that only veterans with legitimate service-connected stressors would receive priority care for PTSD.

Senator **MURKOWSKI**. A 1985 VA report noted that 40 percent of all VA beds are occupied by veterans with mental illness disorders. Is that percentage still that high?

Dr. **GRONVALL**. I believe it is. Dr. Errera, do you have a more current estimate?

Dr. **ERRERA**. The percentage is lower now, in terms of beds.

Senator **MURKOWSKI**. Lower than 40 percent?

Dr. **ERRERA**. It's lower. It was 40 percent, it's now down to the 30s. In part we've cut back the number of beds. I would say the figure is now about a third.

Senator **MURKOWSKI**. Are you suggesting that by cutting back the number of beds we're simply not caring for that percentile difference?

Dr. **ERRERA**. We have been closing about 1,000 beds a year for many years.

Senator **MURKOWSKI**. Throughout the system?

Dr. **ERRERA**. Throughout the system.

Senator **MURKOWSKI**. But my question is——

Dr. **ERRERA**. No, in psychiatry.

Senator **MURKOWSKI**. I'm sorry?

Dr. **ERRERA**. In psychiatry, throughout the system.

Senator **MURKOWSKI**. Oh, in psychiatry. Why have those beds been closed?

Dr. **ERRERA**. I think part of it is the recognition of the growing importance of ambulatory care, the development of new mental hygiene clinics, the development of other noninstitutional programs.

Senator **MURKOWSKI**. OK.

Let's clarify it, because my point is, in 1985 there were 40 percent. Now you're saying it's closer to 30 percent.

Dr. **ERRERA**. Yes.

Senator MURKOWSKI. Is that because there are less veterans that have this chronic mental illness?

Dr. ERRERA. No, sir. I think that's because there are less veterans with chronic illnesses who are in beds.

Senator MURKOWSKI. OK.

And is that a good thing, or a bad thing?

Dr. ERRERA. I think that is a good thing, sir.

Senator MURKOWSKI. All right.

Dr. ERRERA. As long as we have alternative treatment options.

Senator MURKOWSKI. And the reason they're not in beds is that they don't have to be, is that right?

Dr. ERRERA. That's right.

Senator MURKOWSKI. OK.

It's not because we're not providing the beds?

Dr. ERRERA. No, sir.

Senator MURKOWSKI. So, we're providing the beds for those that need that type of treatment, as opposed to those who don't need it.

Dr. GRONVALL. And, Senator Murkowski, if I may, the VA, I think, it's not an overinflated statement to say that in the total mental health community, the VA has been, and continues to be viewed as a leader in finding ways to get chronic mentally ill veterans/patients out of institutions, but more importantly then, provide continuing support in a noninstitutional or a community based system so that they don't just fall between the cracks and not get care.

Senator MURKOWSKI. And you have the figures to support that veterans are not falling through the cracks, they're not drifting under the railroad bridge, whatever?

Dr. GRONVALL. There are some, of course, that are failures, but, yes, our overall record, I think, would withstand critical scrutiny.

Dr. ERRERA. In case some have fallen through the cracks, and become homeless chronic mentally ill, they now love the program which you started, Senator Murkowski. A significant percentage of our HCMI population has been in hospitals before. There's also a significant percentage that are people who have just been out there and have never gotten attention.

Senator MURKOWSKI. How many people are out there that are veterans would you guess?

Dr. ERRERA. The figures from the Institute of Medicine suggest that on any one night there's 750,000 people who are homeless, and over any 1 year there's 1.5 million homeless. And the percentage of veterans in this population in different studies ranges from 15 to 50 percent. The accepted figure usually is a third, sir.

Senator MURKOWSKI. Isn't that an abnormal ratio?

Dr. ERRERA. No. It's a representative figure.

Senator MURKOWSKI. If you take the high figure of what is it, a million and a half?

Dr. ERRERA. It's a representative figure if you look at the age distribution of the homeless. There's two major groups. One is the children, there's a growing number of those. But otherwise, there's a lot of men who are in their forties, and many of these are veterans. And that's why it looks as though there are so many Vietnam veterans.

Senator **Murkowski**. A third of the population in their forties are veterans?

Dr. **Errera**. No. I'm saying that in the population that is homeless there are a lot of men in their forties. Because the elderly people can't make it. It's tough to survive if you're over 60, as a homeless person. Some do, but it's not the rule. Whereas people in their forties and fifties can still cope with the realities of homelessness. And since so many of those are males, a lot of them, not surprisingly, are veterans, Vietnam veterans.

Senator **Murkowski**. How do you handle the relationship between the veteran patient population in the homeless area, and research programs directed to reduce that? Is it a priority in your research area.

Dr. **Errera**. We have extensive evaluation studies, which I would indicate—is distinct from a research study. A research study would be a more controlled study. But we have very extensive clinical evaluation studies. I would think that during the coming years there will be more—more people will be putting in grants to the medical care research program for research studies in this area. That's also being encouraged by the National Institute of Mental Health. But our focus has been on evaluating to see really what works, and for whom.

Senator **Murkowski**. Do people want to work in this program? Does it take a certain kind of a dedicated, committed person?

Dr. **Errera**. I would say doctors are not especially interested in working in these programs. This is not where doctors naturally drift toward. By the way, it's not a limitation on the doctor, necessarily. These are very difficult people to work with. They are not especially grateful for the care. They are not necessarily responsive. I would say that the bulk of the people who are really out there and doing a heroic effort are social workers, and nurses, and technicians, and outreach people that work with the vet center program. The MD's and PhD's play roles that are important, but they're not the bulk of the treating professionals. They are, once these people are brought back to them and they can see them in their offices and in their clinics.

Senator **Murkowski**. Do you have many instances where these people prefer the lifestyle that they are in and when you bring them into an environment where you can rehabilitate them, they want to go back and just simply be left alone?

Dr. **Errera**. There's a percentage of those, sir, yes.

Senator **Murkowski**. And what do you do with that percentage? Do you forcibly retain them?

Dr. **Errera**. No, we don't. I don't believe in that. And the law doesn't allow us, either. There is a population called the young chronics, where this is a serious problem, because growing out of the deinstitutionalization movement, these people never have been exposed to the professional health-care dimension. And it is very difficult to work with those people. I would say that that's under 20 percent of the people we initially contact. These are the people we first go to and they'll say, for one reason or another, they don't want to talk to us. It could be that it's not that they don't want help, but they're afraid of something. But the message that we get is you can't work with me today. Now, some of those people over a prolonged period we may be able to get to.

Senator MURKOWSKI. So in many cases, we can assume people that we see on the street have attempted some type of rehabilitation.

Dr. ERRERA. The people that we're seeing, the vast majority of them, we can make productive efforts to rehabilitate.

Senator MURKOWSKI. I have no further questions of this panel, Mr. Chairman.

Chairman CRANSTON. Thank you, Frank, for staying here while I had to leave.

The meager $60,000 operational funding increase you propose for the new consortium, over the Cleveland funding level certainly would not even come close to covering the cost of inflation over the last 5 years. I certainly understand that funds are tight through VA, but I really don't think this project will be well served by putting it on a budget that is substantially less in real dollars than the funding levels for the failed Cleveland Center. I understand that the National Center Consortium originally submitted a budget for $2.25 million in recurring costs with $1.5 million in startup costs.

John, would you be willing to work with the new National Center staff to develop a more realistic budget that will enable the Center to fulfill its mission?

Dr. GRONVALL. It's easy to say yes to a general question like that. As we established the new center, I believe that has already been done. Every aspect of the VA's medical program is now funded effectively at a lower level than it was several years ago. We've had to make adjustments across the board, and we believe that we have made an intelligent decision about the funding for that center, and that it's not on a budget level that will cause it to fail. We've had to adjust to the funding shortfall, which you, of course, are so well aware of, and that's been the basis of all of our actions.

Chairman CRANSTON. Well, if we find a way to get the moneys in a supplemental, I wish you'd consider how we might develop a more realistic budget. Perhaps we can do that.

Dr. GRONVALL. Correct.

Chairman CRANSTON. On PTSD treatment, John, VA opposes section 201 of S. 13, which would require needed mental health treatment to be furnished to a veteran diagnosed by a designated mental health professional as having service related PTSD, without the need for a pretreatment adjudication by the VA on the issue of service connection. On page 14 of your written testimony it's noted that VA opposes this section, "because it would treat veterans as service connected, when they have not been formally so adjudicated."

As you know, under current law, the category of veterans who were exposed to a toxic substance in Vietnam or radiation from nuclear explosions have categorical eligibility for and indeed inpatient care entitlement to VA care, without the need to be adjudicated as being service-connected for those disabilities. So I'd like to ask this, John. Do you have the same concern about providing care to those exposed veterans?

Dr. GRONVALL. I think there is at least some difference in the two areas that you're comparing. In the case of veterans exposed to atomic explosions, or the Agent Orange exposure, or veterans who were POWs, the law identifies a class of veterans exposed to a hazard, or a problem, and then gives them, by statute, priority for care. None of those are priorities established on the basis of a specific medical diagnosis made by a physician. So I think that is a different approach, and we oppose the idea of establishing a priority category on the basis of a diagnostic definition.

Clearly, if the Congress adopted such legislation, and the President signed it, it would be an additional special category of category A veteran. But we oppose that approach on a diagnosis basis.

Chairman **Cranston**. It seems to me there's a presumption. We were acting on the presumption leaning to the side of the veteran in terms of that exposure. And it just seems to me that we should be making the same presumption about people with PTSD problems.

Dr. **Gronvall**. As a matter of fact, Mr. Chairman, we are currently surveying on a fairly systematic basis all of our facilities to see how big the problem is, where a veteran has a diagnosis of PTSD made perhaps at a vet center, and then is referred for other care to a mental health clinic, or to a VA medical center. We have heard, as the committee has, anecdotes of problems in that area, and so we're trying to get our hands on accurate information to see how big the problem is.

Chairman **Cranston**. Dr. Blank, and Dr. Errera, do you have any opinion on this issue?

Dr. **Blank**. With reference to the statement, and also to my own views, I think that this is a topic with a number of conflicting arguments and counterarguments, all of which are reasonable. I do think that the matter does raise an important conceptual point as to the difference between adjudicated and not adjudicated.

It seems to me that the bottom line on the issue is a question of who should have priority. I don't think there's any question that if veterans diagnosed as having PTSD, but not service connected, were given special priority, that they would displace other veterans who are not service connected who have serious mental illnesses. And in my view, that's the bottom line from a treatment standpoint. I think one simply has to make a judgment as to what the priorities are?

Chairman **Cranston**. Dr. Errera, do you have any views?

Dr. **Errera**. No, I have nothing to add.

Chairman **Cranston**. Then let me ask the two of you another question. As clinicians, could you tell us whether having a veteran with PTSD go through the VA adjudication process might be detrimental to the veteran's eventual course of treatment? And if so, why it might be difficult from the veteran's point of view to undergo such adjudication prior to treatment?

Dr. **Errera**. I think that's a very important point you're raising. There are certainly patients where the issue of service connection and raising it is not one that will necessarily be to the benefit of that person's therapy.

Chairman **Cranston**. Do you have any comment, Dr. Blank?

Dr. **Blank**. I think there are such cases. I think there also are cases where, in fact, it's helpful to the veteran's recovery.

Chairman **Cranston**. In your statement you note that "in the case of PTSD claims" there's been "a very significant percentage of awards of service connection." What's the percentage of awards of service connection in PTSD claims adjudicated in fiscal year 1988?

Dr. **Gronvall**. We'll need to supply that for the record. That's a Veterans Benefits Administration item.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

Percentage of Service-Connected Awards for PTSD

No statistics are available for any period prior to June 1, 1985, regarding the grants and denials of service connection where PTSD is alleged. As of that date we began collecting these statistics on a Special Interest Rating System (SIRS) and maintain a running computation. As of May 23, 1989, SIRS showed 41,013 claims. A total of 22,304 were approved and 18,679 were disapproved for an approval rate of 54.4 percent. The most common reason for disapproval was that a diagnosis of PTSD was not made.

A specific diagnostic code has been assigned to PTSD in the rating schedule since the early 1980's. The Compensation and Pension Master Record as of the end of March 1989 shows that 27,044 veterans who are receiving compensation are service connected for PTSD. An unknown number of veterans were granted service connection for PTSD, or other anxiety disorders based on traumatic experiences, prior to the time a specific code was available to identify PTSD in our computerized records.

Chairman **Cranston**. According to the VA response as provided in my prehearing questions submitted to VA on January 27 in connection with the VA's budget hearing approximately 26,000 veterans are currently service connected for PTSD. Given that the RTI study found that 479,000 veterans currently have combat-related PTSD, the 26,000 figures surely leave a lot of veterans without service-connected status, isn't that the case?

Dr. **Gronvall**. Correct.

Chairman **Cranston**. It seems to me that the GAO report entitled, Need to Update Medical Criteria Used in VA Disability Rating Schedule, released on December 29 of last year, which states that VA cannot ensure that veterans undergoing the adjudication process are given accurate and uniform disability ratings further demonstrates the need for a procedure to ensure PTSD treatment such as would be established if section 201 was enacted. Do you agree or disagree on that point?

Dr. **Gronvall**. Again, the area of VA operation that you're inquiring about is not one that I'm responsible for. I do know, as a matter of general information, that the VA is in the process of taking steps to improve the adjudication process, but a more precise answer would have to come from the VA.

Chairman **Cranston**. Will you supply that for the record?

Dr. **Gronvall**. Yes.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

GAO Statements That Rating Schedule Is Out of Date

We have agreed to do a systematic review of the rating schedule in order to update outdated terminology. PTSD has been recognized as a separate diagnosis only since the 1980 publication of the third edition of the "Diagnostic and Statistical Manual of Mental Disorders" (DSM-III) by the American Psychiatric Association. PTSD is one type of anxiety disorder and as such is properly evaluated under the criteria generally applicable to anxiety disorders. If any change is found to be warranted in the general rating formula for anxiety disorders, such change would also affect PTSD.

A change in the rating schedule would only affect the evaluation of the condition, not basic determinations regarding service connection. The criteria for making the diagnosis and the descriptions of the symptoms were originally contained in DSM-III and were revised in 1987 in DSM-III-R. This information was distributed to the rating boards, and indeed to all elements in the field stations, in various procedural instructions including program guides and VBA circulars. It is these instructions which provide guidance on the issue of service connection, not the rating schedule.

Few areas of disability have received as much attention from VBA in recent years as has PTSD.

Chairman CRANSTON. Your written testimony estimates that $17 million in fiscal year 1990 and approximately $81 million over the next 5 years would be spent if section 201 were enacted. These estimates represent a lot of money and indicate to me that a large number of veterans would receive treatment only if this section were enacted. How many veterans do you estimate would be treated annually if the provision were enacted?

Dr. GRONVALL. Dr. Errera, do you have that figure?

Dr. ERRERA. No, we can get that figure for the record. But what that figure reflects is that our outpatient capability now is full beyond the maximum.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

We estimate that, as a result of this section, approximately 16,000 nonservice-connected veterans per year would be entitled to and receive mandatory inpatient and outpatient treatment. The additional annual cost of outpatient treatment, at $461.50 per veteran, would be approximately $7.3 million. For inpatient treatment, we would make funds available to support 49 additional FTEE (7 per medical region) to enhance the treatment capabilities of one specialized PTSD unit in each region, at a total cost of approximately $2.3 million. We would also establish 30 additional PTSD clinical teams at selected medical centers, each requiring four FTEE, at a cost of approximately $6.4 million, plus a nonrecurring activation cost in fiscal year 1990 of $1 million. Thus, the fiscal 1990 cost of this proposal would be approximately $17 million. We estimate the 5-year cost to be $82 million. Because no funding is provided to implement this provision, health care for other nonservice-connected veterans will have to be curtailed throughout the system in an equal amount.

Chairman CRANSTON. Can we presume that these veterans would receive no VA treatment if section 201 is not enacted? You're nodding your head yes, Dr. Errera.

Dr. ERRERA. Except what they would get at the vet center, yes, sir.

Chairman CRANSTON. John, VA also opposes section 202 of S. 13, which would extend the reporting requirements of VA's Special Committee on PTSD. The written testimony expresses concern over the constitutionality of the reporting requirements and suggests that the reporting requirement, "would also seem to defeat the very benefits the committee is established to provide, to advise Department officials in a manner permitting the formulation of changes in VA policy, and at the same time it would have the effect of eroding the Secretary's authority." Although we understand VA's and Justice's concerns, what we're concerned about here is receiving timely, informed information on PTSD-related matters. The concurrent requirement was included in this provision because VA has failed to provide any of the special committee's five annual reports in a timely manner.

For example, the fifth annual report which was due on Friday, February 1, still hasn't been delivered. When can we expect it?

Dr. **Errera**. In September, sir. And the delay is related to the request for further analysis of the Research Triangle Institute study by the special committee.

Chairman **Cranston**. John, at last year's hearing on PTSD on July 14, 1988, exactly 11 months ago, I asked you what VA intended to do about the tremendous number of veterans that RTI had identified as suffering from PTSD. Your response was that you would study the issue in order to determine the best way to address that problem. At the budget hearing for fiscal year 1990 on March 6, I asked what VA intended to do to care for the hundreds of thousands of veterans that were suffering from PTSD. Once again the answer was that VA would study the issue in order to determine the best way to address the problem. During the April 6, 1989 oversight hearing on VA health care, I again asked what the VA was doing to provide for the hundreds of thousands of veterans whose lives were being disrupted by PTSD, the answer stayed the same—VA would study the issue in order to determine the best way to address the problem.

Today's testimony is, I think, really even less satisfactory. It clearly raises doubts on page 14 about whether VA has any belief that a higher priority is needed for PTSD treatment. After a year's time to study the matter, your testimony today is an enormous disappointment. You've had ample time to study the issue four times, and still you have come forward with no plan, no recognition of the magnitude of the problem, and no commitment to do anything affirmative to meet the enormous unmet demand for PTSD care. I truly can't believe you would return here for the fourth time in 11 months with such an unsatisfactory line and then ask Congress, please, not to legislate any priority at all for PTSD care so you can devise ways of meeting a need that you really fail to acknowledge.

Worse yet, your testimony includes a not-too-veiled threat that you might have to curtail access to some veterans with chronic mental illness if we enacted section 201. I wonder why that would be. Is there perhaps some mental health quota of VA health-care dollars on patients? Frankly, I find this record of inattention, procrastination, and insensitivity to service-related conditions that are crying out for VA care to be totally unacceptable and very, very disheartening.

After that, do you have any comments?

Dr. **Gronvall**. Yes, let me make a few comments, Mr. Chairman. And then I'd like Dr. Errera to describe in more detail the status of our review of that report and the program plans being formulated to address the problems it documents.

The matter is a complex one. The report itself documents the very great extent to which individuals with PTSD choose not to seek treatment, and the complexity of grappling with that issue and the magnitude of the apparent number of untreated and unreached veterans, I think, has led to a requirement that the report and our program plans be given careful scrutiny. We've involved the special committee heavily in that review. They've asked for additional analyses, additional comments and that, of course, is why the report from the special committee is running late.

Chairman **Cranston**. How about the long waiting lists, very long waiting lists, at a number of places where veterans can't get in?

Dr. **Gronvall**. I could only say, Mr. Chairman, that this year we have reduced the quantity of care in every category that we're providing to veterans. And while the need is great we are unable to meet all demands for health care.

Chairman **Cranston**. We're talking about service-related treatment. Are you turning away service-related people?

Dr. **Gronvall**. To my knowledge we are not explicitly turning away any veterans who are service connected.

Chairman **Cranston**. Except that they have to wait a very long time.

Dr. **Gronvall**. In the case of elective care that can be scheduled, the waiting times have increased. And we've put that information clearly on the record.

Chairman **Cranston**. Do you consider PTSD care to be elective care?

Dr. **Gronvall**. The care is in a sense elective, as contrasted to emergency care, or a medical emergency where there is a life threatening situation that demands immediate medical or surgical attention. In that context, care of PTSD extends over some time, and is in that context and with that definition, elective.

Chairman **Cranston**. Well, there are many clinicians that have said that there are people waiting for care who are in acute need of treatment and not getting it.

Dr. **Gronvall**. I agree with that.

Chairman **Cranston**. Well, then we have a serious problem.

Dr. **Gronvall**. I agree.

Senator **Murkowski**. Mr. Chairman.

Chairman **Cranston**. Yes.

Senator **Murkowski**. I wonder if I could ask the gentlemen, do you have information on a number of veterans who request VA treatment for PTSD but don't receive it?

Dr. **Gronvall**. Dr. Errera, or Dr. Blank? Maybe both of you could comment? Dr. Blank.

Dr. **Blank**. We don't have quantitative data at this point in time, other than the waiting lists for inpatient treatment on the PTSD specialized wards. We are carrying out a survey currently of referrals between VA medical centers and vet centers in both directions, which will give us some quantitative information about whether or not there's a restriction on care.

For example, we will be collecting numbers of veterans referred from the vet center to the medical facility who can't be seen, either for evaluation or treatment.

Senator **Murkowski**. Let me ask you a professional question. We've got 197 Vietnam vet centers around. What is their capability to treat or provide some relief for PTSD?

Dr. **Gronvall**. Dr. Blank can quantitate it, but I would say they are a very large and important part of our capability to provide treatment to veterans suffering with PTSD.

Senator **Murkowski**. Yes, but how effective are they in this area?

Dr. GRONVALL. Dr. Blank? I believe they're effective. Dr. Blank can back that up with data or comments from formal evaluations that have been made.

Senator MURKOWSKI. The question that the Chairman has posed to you folks, is the inability—according to his statistics—of VA to relate to this. I'm curious to know how this interacts with the vet center's capability. And I'd like a differentiation. You people are speaking professionally of VA's ability to meet this demand, and we've heard the criticism from the chairman of your capability. Do the various programs work hand-in-hand? Do they work independently? Are they being utilized? We're expending $40 to $50 million a year to keep vet centers open, and there's been criticism as to their effectiveness in many areas, including this. I would ask the chairman, when we're critical and question the effectiveness of this program, are we including the capability of the vet centers in it?

Dr. BLANK. The vet centers have been at the cutting edge in the provision of treatment for PTSD for the past 10 years. About a third of vet center clients are seen for PTSD and are provided help. And that accounts for around 70 to 75 percent of vet center visits.

From a standpoint of effectiveness of service, all indicators we have are that vet centers are providing quite effective help for PTSD. There are, however, two caveats. In the first place, the readjustment counseling service vet centers is a small program. The total annual budget of all vet centers is less than that of any one of approximately 125 medical facilities. There are a total of 813 FTE at work nationwide. The number of sites, 194, sounds large. But it's important to keep in mind that the average staff size for each site is four.

In addition, vet centers have responsibilities for other readjustment problems besides PTSD. So, I think, the vet center piece of PTSD treatment is quite important. I think the services are effective. It's a very small piece. The other thing I should mention is, that vet center staffs do not include psychiatrists. They do include a mix of psychologists, social workers, professional counselors, and para-professional counselors. What that means is that a certain percentage of veterans with PTSD, who have other psychiatric problems in addition to PTSD, such as alcoholism, may well need treatment at a medical facility at a greater level of sophistication and complexity, including, for example, medication treatment.

Senator MURKOWSKI. Wouldn't that be a natural referral from the vet center?

Dr. BLANK. Indeed. And such referrals go on, on a daily basis nationwide.

Senator MURKOWSKI. Well, I'm just wondering in your response to the chairman, if you were including the contributions of the vet center in the rehabilitation effort, or if you were disregarding that in the question of your ability to provide adequate rehabilitation?

Dr. ERRERA. I think both programs work very well together. And as Dr. Blank described, patients are referred back and forth between the two. The mental hygiene clinics, the day treatment centers see many veterans with PTSD. I don't think we can limit ourselves to the 16 specialized programs. Those are very important programs. But all of the other general psychiatry programs are seeing a lot of PTSD patients. The general outpatient clinics are seeing a lot of PTSD patients. So there is a more comprehensive network available. That doesn't, though, undermine the importance of the chairman's question, there are still a lot of people out there that haven't been seen, and I think we have to remember that this is a population that often is quite alienated, and that's why the vet centers were put where they were, out in the storefronts, where they can do outreach, and that is time consuming.

Senator MURKOWSKI. Do you think the criticism of the chairman is justified in this regard?

Dr. GRONVALL. My answer is that there is an unmet need. I believe that the harshness of the criticism does not take into account things that we have done to expand our capability of providing PTSD treatment, the demonstrated record of such expansions, and the reality of overall declining support. The chairman interpreted our comment in our statement that other veterans would be displaced as a threat. I think it is surely not intended as a threat. It is a matter of fact statement that with declining resources if the priority for one class of veterans is increased, within a fixed operating budget, other veterans will be displaced from care, since all of our funds are now being expended on care.

I appreciated very much the chairman's complimentary comments about our new national center and we went through a careful process to ensure that that will contribute. I mentioned in my oral opening comment that just within recent weeks we have assigned staff to create 23 additional PTSD clinical teams at our medical centers. That follows on some earlier staffing allocations of a similar sort. So we have taken steps, that from my perspective, reflect priority for this care. I completely agreed with the chairman's criticism that the RTI report documents a large number of veterans with PTSD whose needs are not being met. So, I am not in any way trying to minimize the problem.

Senator MURKOWSKI. Well, my question was structured in such a way, Mr. Chairman, as to allow them a rebuttal in doing that.

I have to step out for a minute.

Chairman CRANSTON. Let me say, Frank, about the vet centers, that the vet centers have not had psychiatrists there, obviously. They aren't expected to do that, but they have recognized that certain people need help. They've sent them to the VA, and then they don't get the help at the VA. And as to vet centers generally, Senator Simpson requested a report from the GAO in 1986 which came back with a pretty good report on their effectiveness.

Senator MURKOWSKI. I think you'll probably get a rebuttal from Dr. Errera on that.

Chairman CRANSTON. Any further rebuttals?

Dr. ERRERA. I would wonder, Senator Cranston, why you say they don't get any good help from the medical center. I think that we see a lot of people in our mental hygiene clinics and on our inpatient services referred from the vet center. And we really work with them very effectively.

Chairman CRANSTON. What I was saying was that people go to a vet center, the vet center thinks they need psychiatric help, they refer them to the VA, then they wait in line.

Dr. **Errera**. Well, if they're category B. But if they're category A and there's capacity in the outpatient clinic, we put them right at the top of the list.

Chairman **Cranston**. But they don't become a category A until they've waited a couple of years and got adjudicated service-connected status.

Dr. **Errera**. No, a number of them are also poor, sir.

Chairman **Cranston**. Well, it's not clear that that's the way it works.

Dr. **Gronvall**. Oh, I think it's quite clear that veterans seeking care are first evaluated by a professional to see what care is needed, and then if they are not already service connected, they're subjected to the means test, and in regard to mental health care, if the veteran is either service connected or poor, in other words meets the definition of category A, they are at the top of the priority list and their care is mandated. So it works explicitly the same for mental health care as other kinds of care.

Chairman **Cranston**. Well, let's see what the survey that we've requested shows on that score. I have great questions about the fact that all veterans are getting that kind of a swift accommodation.

Following up on an earlier question, I believe you've now received the RTI study evaluation from the special committee, is that correct?

Dr. **Gronvall**. Dr. Errera.

Dr. **Errera**. Yes, sir, it arrived last week.

Chairman **Cranston**. Why could we not get the special committee's fifth annual report now without the RTI study evaluation in it, and have you submit the committee's RTI evaluation separately after you have reviewed it?

Dr. **Errera**. I thought that a member of my staff had spoken with a member of your staff and had talked about a September date. I may be wrong on that.

Chairman **Cranston**. Well, it was due in February. Why couldn't we get the part you have now, and submit the rest later?

Dr. **Gronvall**. Let us review the report and see if there's a way to subdivide it into two categories and deal with it that way.

Chairman **Cranston**. Please do that.

Dr. **Gronvall**. We'd be glad to review that.

Chairman **Cranston**. Would you let us know next week how you're doing on that?

Dr. **Gronvall**. Yes.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The VHS&RA is subdividing the Fifth Annual Report of the Chief Medical Director's Advisory Committee on PTSD and will forward it to the Congress in the near future.

Chairman **Cranston**. At our April 6 oversight hearing, we discussed the reports we were receiving of veterans who had been referred by vet centers to VAMC's for PTSD-related problems, but were being denied clinical assessments. At that time you agreed to supply information on this situation. Subsequently, VA submitted a written response indicating that vet center preliminary information suggested that "it is becoming increasingly difficult for category B and C veterans to receive evaluation and treatment for PTSD at VA medical centers." And that a survey of VAMCs and vet centers was being done to determine whether veterans were indeed being turned away.

Yesterday, the committee received from you a timetable showing that the results would not be available, at the earliest, until after July 28. This is really too late, John. Our markup on this legislation is scheduled for July 20. So could you please expedite that and get us results by July 14?

Dr. GRONVALL. We'll surely look again at the timetable, and if it is possible to complete the analysis and do it by then, we will.

Chairman CRANSTON. Please do.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

After consultation with relevant staff and review of the timetable, we will submit the requested information regarding referrals for PTSD treatment between vet centers and medical centers/outpatient clinics by July 14, 1989. This submission will entail survey results for the month of May 1989. In addition, this survey will be repeated for June 1989. The June 1989 data will be available to VA officials by July 20, 1989 and can be submitted to the Senate Committee on Veterans' Affairs by July 31, 1989.

Chairman CRANSTON. John and Dr. Errera, I want to stress to you personally my unhappiness and frustration at the apparent lack of concern for congressional intent exhibited by a use of the $5 million appropriated specifically for PTSD treatment in fiscal year 1989. As I stated in my May 15 letter to you, John, that money was intended for treatment and treatment only, not for education, not for evaluation, not for research, not for administrative expenses, for which over 40 percent of the $5 million is being used. I look forward to a rapid and responsive reply to my letter, and when could I get that?

Dr. ERRERA. I could give you part of the reply right now, sir, if you'd like it.

Chairman CRANSTON. I'd rather have it in writing from you. Give it to us in writing.

Dr. ERRERA. Fine.

Chairman CRANSTON. When will we get it?

Dr. ERRERA. Next week, 2 weeks.

Chairman CRANSTON. How about next week?

Dr. ERRERA. All right.

Chairman CRANSTON. Thank you.

Yesterday, VA released its long awaited study of VA mortality within VA medical centers. As you're aware, so-called likely quality of care problems were found in 5.1 percent of a sample of deaths in all VA facilities, and 3.7 percent likely problems were found in a sample of medical/surgical facilities, a staggering 10.4 percent of likely problems were found in a sample of deaths occurring on medical/surgical wards by primarily psychiatric VA hospitals, almost three times as many at VA general medical and surgical hospitals. How long have you had these results?

Dr. GRONVALL. That information has been in our hands for, I believe, about a month and a half, something of that order, the final analysis of the results.

Chairman **Cranston**. So you've had time to think about it?

Dr. **Gronvall**. Yes.

Chairman **Cranston**. What's your preliminary evaluation of the figures? Are they high, low, or what you expected?

Dr. **Gronvall**. I'd need to describe the context of doing the study. The overall study approach was to take the mortality experience of each individual VA hospital and compare it with all VA hospitals. So on that basis there's no way to say that the overall mortality experience is high or low, if by that is meant a comparison, let us say, to private sector care. So what it does is identify individual medical centers, or parts of medical centers programs, which on the basis of this kind of statistical analysis appear to have a mortality rate higher than would be expected, if they were performing consistent with the experience of all VA hospitals.

At the present time, having completed the review of the specific cases that were identified, we are now documenting what steps had been taken at the medical center if the case had been earlier reviewed back when the death occurred, or in the absence of that, what steps might now be taken on the basis of finding that there was a problem in the quality of care of any individual patient.

I would make just one other general point that I think is very important, and I think, unfortunately, has often been overlooked in publicity about this study, namely that the VA undertook the study of its own volition. The Health Care Financing Administration had developed the general methodology of analyzing mortality. We, without external prompting, wanted to conduct such a study in the VA explicitly on the belief that it is part of our responsibility to use every reasonable tool we can find to see whether we can find evidence of problems so that we can take corrective action. I have been regularly asked, and I've been asked within the past 24 hours, what should be said to individual veterans who are thinking about going to the VA or to one of the hospitals that's reported in this study. My answer to that is to say that I think it should be reassuring to veterans as a group, or to individual veterans that the VA itself cares enough about its quality to subject itself to this kind of self-scrutiny, voluntarily, in the hopes that if it turns up problems that had been previously unrecognized, that appropriate action and corrective action, and improvement of quality could be made. And that was the basis of doing the study.

Chairman **Cranston**. I assume you share my concern about the rate of deaths in the medical/surgical wards of primarily psychiatric hospitals?

Dr. **Gronvall**. Yes, I do. That stands out of the study. We have discussed in some detail how to translate that observation into some useful information as to what it means and what we can do about it. And that deliberation is going on. But the observation certainly was made by us and is being followed up.

Chairman **Cranston**. How would you explain that these problems were not identified through previously established quality assurance mechanisms prior to the study?

Dr. **Gronvall**. It is not the case that the problems were not identified. The phase that we're going through now is to compare this approach, which identified problem cases, had them reviewed by physicians from outside the particular medical center, and we are now going back to the hospital's records and we are finding that a significant number of the cases reviewed through this study approach had, in fact, been reviewed in the medical center at the time the case occurred, and in many cases corrective action or appropriate actions had been taken. So it is not the case that all of the deaths, or even a majority of the deaths reviewed in this study were first identified as being a problem as a result of this study.

Chairman **Cranston**. To what do you attribute the very high likely quality of care problems in psychiatric facilities?

Dr. **Gronvall**. I don't have a conclusion that would withstand scrutiny. I think, as a general observation, it is the case that in a hospital—and I'd like Dr. Errera to comment on this—in a hospital that is primarily psychiatric, the patients being treated there often—and that's the reason they're in the hospital—have very serious emotional problems. They display all kinds of complicated and very difficult symptoms and manifestations of their mental problems, and when a medical problem is superimposed on such a serious emotional problem, it is much more difficult to recognize and appropriately treat. And so my kind of preliminary assumption is that that difficulty of dealing with a serious, and in this case life threatening or life taking, medical or surgical problem in a psychiatric hospital in a psychiatric population is much more difficult and leads to the kind of problems that surface when those records are reviewed against a very high standard of saying did this patient receive fully appropriate care on the best medical or surgical standard.

I'd be pleased to have Dr. Errera comment on that as to whether he shares that sense, or has other comments.

Dr. **Errera**. I would add one other thing, which is that a number of these patients may be the old psychiatric medically infirm patients. How many of these people died normally on the medical ward after having spent 30 years, 25 years in an institution? So that the makeup of the population may be one where these people would die, not because a mistake was made. So we need to distinguish what is a problem, as you said, related to clinical care, and what is part of the natural evolution of this population that spends, unfortunately, so many years in the institution.

Dr. **Gronvall**. Mr. Chairman, if I may, another sentence or two. I want to ensure that you and the committee, or the public, does not sense any tone of defensiveness in my response to the concern about does this mean something special about medical care in our psychiatric hospitals. If it turns out, as a result of this study, that we have surfaced a problem that is real, that we can then, obviously, take appropriate actions in response to, I will say the study succeeded in a very important way. We're right now at that very difficult stage that self-scrutiny always brings, when you surface the record of a problem before the time that you have a full explanation as to why it occurred, or what you're going to do about it. And that's always difficult, and everyone always points to the Federal fishbowl as being a complicating factor.

We undertook the study knowing that it would be subject to that kind of scrutiny. It is and has been our intent from the beginning, to follow through on any finding of that sort that comes out of the study. And again, I think that's the importance of having conducted the effort. So I am not at all concerned about your expression of concern about our psychiatric hospitals, or the suggestion that the GAO ought to be asked to review our followup and see if there are other things that should be done that we might not have come up with. As you know, the study has in fact been reviewed twice by the GAO, and once by the Office of Technology Assessment. They complimented us on the improvements to the methodology we had made compared to what HCFA had developed. So, we welcome that kind of outside scrutiny very much.

Chairman CRANSTON. Thank you. The committee counsel has some followup questions.

Mr. STEINBERG. I just wanted to pursue the quality assurance mechanism. And your response was that it's not the case that they were not identified by your regular quality assurance mechanisms. A significant number of the cases, which were identified in the study, had been reviewed at the local medical center. And you went on to say that it's not the case that all of the deaths were first identified here. Now neither of those statements really address the basic thrust of the question, that is, that this study did produce data in the aggregate about mortality at specific hospitals that other quality assurance mechanisms had not produced in the aggregate.

Dr. GRONVALL. Absolutely.

Mr. STEINBERG. And did make it possible for you, when confronted with that aggregate data, to go back and do a followup study at those individual facilities to try to refine the information further.

Dr. GRONVALL. Absolutely.

Mr. STEINBERG. In other words, you're not saying that even a majority of those cases that were found had been reviewed? You said that a significant number of them——

Dr. GRONVALL. Yes, the first report I got, which was a partial sample, was that something over half of the deaths reviewed as problem cases by this methodology had been earlier reviewed at the medical center level, had also been viewed there as problem cases and in a significant number of those some actions had already been taken 1½ or 2 years ago at the medical center level. But I don't have the total report on that. We will have that, I think, within about the next 2 months.

Mr. STEINBERG. So I take it that the final value of this study will be able to be determined only after further refinements and investigation are made and the followup action is taken when it can be seen whether there indeed are trends or problems that require corrective action. If there are, then the study has vindicated itself?

Dr. GRONVALL. Correct. If I may expand that in a sentence or two, the kind of overall observation about psychiatric hospitals compared to other hospitals needs followup. And then the extent to which individual cases had been previously reviewed and appropriately addressed, also, of course, needs specific followup.

I appreciate those questions that help clarify the response I gave earlier.

Chairman CRANSTON. Can you expedite your followup review of the six psychiatric facilities? There's an alarming increase there, and I think we ought to know as fast as possible what the situation is.

Dr. GRONVALL. Yes.

Chairman CRANSTON. In the Secretary's undated letter to me, received yesterday, accompanying the mortality report, he states in regard to the statement in the report that no general statement about the quality of VA care can be drawn from the study, as you have said, saying "this statement and other qualifiers led me to a conclusion that this specific report did not represent a particularly effective use of VA resources." In other words, you seem to be saying that VHS&RA wasted his time and money doing this study. John, how much was spent on the study, including the cost of all VA salaries and benefits?

Dr. GRONVALL. I don't know the cost of the study.

Chairman CRANSTON. Could you get that for the record?

Dr. GRONVALL. Yes.

[Subsequently, the Department of Veterans Affairs furnished the following information:]

The estimated cost of the Mortality Rate Review was $653,195.

Chairman CRANSTON. What are your views of whether the study was a waste of VA time and money?

Dr. GRONVALL. Having initiated the study, of course, I have proprietary interest in it. I think the answer to the question in a full sense won't be possible until we've completed the kind of thinking that I was describing earlier, after the study is fully completed. I believe the Secretary was very clear in his discussions with me, and he included it in his letter, that it was a disappointment that this kind of study, even though it's a very large effort, doesn't lead to a crisp, clear conclusive answer as to what the quality of care is in the VA, or how it compares to the community. I certainly agree totally with his establishing that as an objective. I think it's an unfortunate fact that the hospital and health-care world has not yet been successful in devising a measuring stick of quality that can be applied in that way, and that has validity and credibility. I think the HCFA analysis and our refinement of it are contributions of tools that move in that direction, but they are only tools to move in that direction. They are surely not the final answer, and we never described this as an effort that would lead to that kind of explicit, simple, final, conclusive yard stick. A lot more work needs to be done. My hope is to have the VA an active and important contributor to the development of such a tool in American medicine.

Chairman CRANSTON. Thank you.

We have no more questions for you, and I appreciate your presence this morning.

Dr. GRONVALL. Thank you.

Chairman CRANSTON. The next panel is composed of two individuals who are especially qualified to testify in mental health issues. First, Dr. Spencer Falcon, who is representing the National Association of VA Chiefs of Psychiatry, and Dr. Kenneth Klauck, President of the National Association of VA Chiefs of Psychology.

Dr. Falcon is a member of, and I understand will soon head, the VA Special Committee on PTSD. We look forward to his comments on PTSD. We're pleased you're both here today and look forward to your testimony. And Dr. Falcon, would you please lead off?

STATEMENT OF DR. SPENCER FALCON, CHIEF OF PSYCHIATRY, ANN ARBOR VA MEDICAL CENTER, ON BEHALF OF THE NATIONAL ASSOCIATION OF VA CHIEFS OF PSYCHIATRY

Dr. **Falcon**. Thank you, Mr. Chairman. I'm the Chief of Psychiatry at the Ann Arbor VA, and I'm pleased to appear before the committee to present the views and concerns of the National Association of VA Chiefs of Psychiatry, and the APA regarding the current legislation before the committee.

The bills being considered today are manifest evidence of your concern for problems that exist within the mental health delivery system of the Department of Veterans Affairs. This legislation has in common the implicit and explicit statement that current services available to veteran patients within the VA, suffering from a host of mental disorders, is to this point inadequate. The inadequacy exists in terms of access to care, availability for special populations, programs in which care is provided, and the availability of trained psychiatrists. Pending legislation, I believe, represents further evidence of the commitment of this committee to these important issues.

In my written statement, which you have received, I point out some of the information that was obtained from the National Vietnam Veterans Readjustment Study, which amply demonstrates the unmet need of Vietnam veterans with post-traumatic stress disorder. The provisions of S. 13 to expand eligibility to include those veterans, even if such a disorder had not been determined to be service connected is, I believe, essential for assuring access to care of much of this population. Substantial proportions of Vietnam veterans with post-war readjustment problems have never used the VA for their mental health treatment. Provisions in S. 13 to provide focused attention to special population is again supported by information from the National Vietnam Veterans Readjustment Study. It is important to note that there has been substantial demonstrated need in the special populations that have already been studied.

Also, as a member of the Special Committee on Post-Traumatic Stress Disorder, I would express my support and the support of the committee for the reporting relationship between the special committee, VA, and Congress, as is contained in section 202.

Post-traumatic stress disorder is the only psychological condition that by definition is military war-zone related. The Veterans' Administration treats many critical medical conditions that have no relationship to combat or military related service. Recognizing the need for these services, post-traumatic stress disorder needs to be prioritized and funded to address the strong need indicated by the results of the national study. To that end, we strongly support section 204 of S. 13, which addresses funding for post-traumatic stress disorder programs. It is essential that we track resource commitments to this problem, and that adequate funding be prioritized to meet the needs of this veterans group.

The homeless and chronically ill legislation and the compensated work therapy legislation both point out an awareness on the part of this committee of the difficult, seemingly impossible task of providing a continuum of care to those individuals deinstitutionalized by our more efficient system. We need programs such as compensated work therapy to help address the clinical impact caused by the reimbursement methodology in the VA, which has shortened the length of stay and increased the episodes of care for psychiatric patients, our most vulnerable patients, frequently.

Such programs would help stabilize patients in less expensive alternative treatment settings, but they would also make up for the fact that our system was originally devised to have longer lengths of stay. So we need to create these programs for HCMI and compensated work therapy to make up for some of our innovative programs since 1980.

I would also like to express our support for the MIRECC bill. We believe that an increased attention to psychiatry research funding is essential to decrease the level of psychiatric vacancies within the VA. The problems associated with recruitment and retention would be significantly diminished if a special effort were made to improve the professional milieux in which these physicians work. The establishment of a MIRECC would have a positive impact, well beyond the institutions designated to have centers. The reputation of psychiatry within the VA, and the commitment of the VA to mental health and substance abuse issues, would be highlighted by the establishment of such centers.

Finally, I'd like to speak about a linkage of these proposed legislations in that many of the individuals that we speak about that would be covered by the Homeless Chronically Mentally Ill legislation or the Compensated Work Therapy legislation are also included in the veteran population known to have post-traumatic stress disorder. The interrelations of these programs and conditions particularly when it relates to dual diagnosis with substance abuse, and other mental conditions, requires us to be progressive and proactive in our approach to their treatment needs. It may be time not only to track our resource commitment to post-traumatic stress disorder, but also to look at resource commitments to mental health in general.

I believe we must have an increased awareness and sensitivity of the needs of veterans with mental health and substance abuse problems, within our system, and that we must commit ourselves to take whatever steps are necessary to ensure that the care they receive is appropriate, and that the availability of this care is protected during this period of severe budgetary constraints. It appears to the chiefs of psychiatry around the country, that this is not the case. Mental health services we see as decreasing rapidly, and we believe more rapidly than other related services. We see already inadequate levels being further eroded, and we feel that we no longer can adequately provide the treatment that is necessary.

Thank you.

[The prepared statement of Dr. Falcon appears on p. 143.]

Chairman CRANSTON. Thank you very much. We appreciate your testimony very much.

Dr. Klauck.

STATEMENT OF DR. KENNETH A. KLAUCK, PRESIDENT, NATIONAL ASSOCIATION OF VA CHIEFS OF PSYCHOLOGY

Dr. KLAUCK. Mr. Chairman, I am Kenneth A. Klauck. I am Chief of the Psychology Service at the Clement J. Zablocki Medical Center, Milwaukee. I am testifying today on behalf of the 90,000 members of the American Psychological Association and the Association of VA Chief Psychologists, of which I am the current President.

APA is the major scientific and professional society representing psychology in the United States. Many of our members are researchers and practitioners in the Department of Veterans Affairs regional centers and hospitals across the country. The Association of VA Chief Psychologists represents 130 Chiefs and 50 Assistant Chiefs of Psychology Services within the Veterans Health Service and Research Administration.

Thank you for inviting us to testify on legislative initiatives under consideration by the committee to create mental illness research, education and clinical centers (MIRECC), to enhance programs for veterans suffering post-traumatic stress disorder, to extend the Homeless Chronically Mentally Ill Program, and to expand compensated work therapy with a therapeutic residence program. We strongly support the efforts of the committee to assist our Nation's veterans during these tight budgetary times.

Provisions in S. 13 that allow for the expansion of research on PTSD, and the treatment of combat vets suffering from this disorder are timely reminders of the work that is yet to be done in the VA. Psychological research has shown how devastating PTSD can be for Vietnam veterans as well as combat veterans from World War II and Korea. PTSD is a psychological disorder that is in the most basic sense "service connected".

Section 201 of S. 13 ensures the VA will offer treatment to veterans regardless of whether there has been a finding of service connection. This policy waiver will make it possible for the 829,000 veterans who are experiencing PTSD-like symptoms to access the VA's health-care systems as evidenced in the findings of the Research Triangle Institute. Psychological interventions have been effective in treating this chronic condition and we believe this section will assist in addressing the scope of the problem. In September of last year our association wrote letters in support of Senate bill 2011, which contained the initial proposal for the establishment of MIRECCs. I'm particularly pleased that this proposal follows the same model as the (GRECCs) Geriatric Research, Educational, Clinical Centers.

MIRECCs can offer the proportional monetary support to research that is in line with the need. VA psychologists agree that research is an investment in the present and future of our veterans. Without a doubt, it improves care. Also, not to skirt the issue of budgetary considerations, research funding is cost effective. I commend you, Senator, and the committee for their support of the MIRECC. Depression, AIDS, PTSD, alcoholism, substance abuse, and a host of other disorders are serious national problems that affect veterans and present a challenge to VA researchers and health-care professionals.

We support the provisions of S. 13 that calls for a study of the prevalence of PTSD in Asian-Americans, American Indians, Native Hawaiians, other Native American Pacific Islanders and Alaskan Natives. Likewise, we support Senate bill 192.

For the last few years, VA has dealt with the chronically mentally ill, homeless veterans by utilizing a new approach of the Homeless Chronically Mentally Ill Program, which was begun in 1987. It has served thousands of veterans through a program of community outreach, health-care service and residential treatment. This program responds to a significant need based on estimates that range between 18 and 51 percent of the total homeless population as being made up of veterans, many of whom served in Vietnam. The homeless program's track record has been excellent and we strongly support S. 405 which authorizes permanent program status. The homeless problem can only be solved by a long-term commitment.

Lastly, I would like to take the opportunity to comment on proposals that would make changes in the Compensated Work Therapy (CWT) Program. In doing so, I would like to acknowledge your efforts, Senator, especially over the last several years to see that this dynamic program makes it possible for so many veterans to acquire meaningful job skills, returning them to the community as fully functioning, taxpaying members. On behalf of the Chiefs Association and the APA, we appreciate your efforts in this regard.

Psychologists in the VA have a long history of providing comprehensive vocational rehabilitation assessments and program support within the VA medical centers in cooperation with our veterans benefits colleagues and rehabilitation services. CWT is a valuable tool in the treatment of mentally ill veterans and we would certainly like to see expanded opportunities for training as well as the addition of therapeutic housing. Transitional housing of this type allows for inexpensive living arrangements in addition to an expansion of the rehabilitation program beyond the environment.

The Chief's Association and the APA were encouraged to note the introduction of Senator Murkowski's bill to modify and expand the CWT program and indicated their support in letters to the Senator last month. We believe it offers the kind of flexibility that will serve the CWT program and the veterans it assists. It also removes some roadblocks that have in many respects limited the potential of the program. One such improvement involves the authority for the VA to contract with any source, government or VA. Another allows funds from the STRAF account to be used for educational travel.

Providing therapeutic residences (TR) would be, as mentioned, a great benefit to the success of the CWT program. I was glad to see the VA must work with the community to ensure acceptances of therapeutic residences and therefore, the ultimate success of this program. In addition, the establishment of nonprofit corporations to provide a funding mechanism above and beyond any Government contribution is a complement to the VA's expanded CWT mission.

You have my written testimony. In any event, we pledge our assistance to the committee as you endeavor to formulate a workable model of CWT.

Thank you.

[The prepared statement of Dr. Klauck appears on p. 154.]

Chairman **Cranston**. Thank you very much for your testimony. I'm going to have to step out for a moment. But if there's no objection from any other member of the committee, and I hear none, counsel will proceed with the questions until I get back.

Mr. **Steinberg**. Dr. Klauck, I think you were here for the exchange between Senator Cranston and Dr. Gronvall, with respect to the question of whether veterans with PTSD are being turned away at VA medical centers. Do you have any information on that situation that you could share with us?

Dr. **Klauck**. I do not have any specific information, but I will certainly try to get you some, as far as figures.

Mr. **Steinberg**. If you could provide that for the record, please. Perhaps your organization could make a sample inquiry of some of the larger medical centers, and give us that information.

[Subsequently, Dr. Klauck furnished the following information:]

To date, I have only been able to obtain anecdotal material regarding whether veterans with PTSD are being turned away. I will continue to pursue this matter and send any information I obtain at a later date.

Mr. **Steinberg**. Dr. Falcon, would you like to comment on that?

Dr. **Falcon**. Yes, I would. I have anecdotal information regarding this in conversations from the Special Committee on PTSD that relate to representatives from RCS who are on the committee, who have reported that they believe that this is the case. That patients who they had previously been able—who had previously been treated as B's and C's were no longer being seen by the medical centers. I don't have an idea as to scope.

Mr. **Steinberg**. Is that an issue the special committee has been looking at, or will be looking at?

Dr. **Falcon**. We are beginning to look at it now. As it has come up with the recent changes in operation that have reduced the ability to care for some of the B's and C's. We have looked at the possibility that this would happen, and are planning to look at that in detail over the coming year.

Mr. **Steinberg**. Do you have a general view to share with the committee, as a member of the VA Special Committee, on the current situation regarding access to treatment by veterans with PTSD?

Dr. **Falcon**. Well, a general view. I think that much of the discussion that went on earlier this morning highlighted the point that's in contention as to whether or not a patient needs to be adjudicated or should be required to be adjudicated to be service connected, in order to be able to have the care.

In previous work that the special committee has done with the mental outpatient study, and with studies that the vet center has done, we have—let's say that correctly, and that included studies of both mental hygiene clinics and vet center patients, it was found in both of these instances that the vast majority of patients that were clinically diagnosed as PTSD and thought to require treatment had not been adjudicated as being service connected by the Department of Veterans Benefits. This appeared to be consistent across both sides.

From that standpoint if these individuals had been category B, or less entitled, they would not be entitled, at this point, to treatment. Second, we have found in some recent work that a large number of these patients required hospitalization in the 6 months before and after their contact point. That would mean that all those patients who are not entitled to VA benefits because of their category B or C status, who are seen and diagnosed at the vet centers, and who the vet center people may feel require psychiatric hospitalization for their condition, would not be eligible for inpatient psychiatric hospitalization, even if a VA employee at the vet center felt that this patient needed it.

So from that standpoint I would say that this is a problem.

Mr. STEINBERG. That's exactly the problem that we're trying to address, and you've spelled it out very eloquently.

We understand that the psychiatric service at Ann Arbor is providing some assistance to the psychiatry service at Battle Creek. Could you give us a brief description of what's involved in that, and why it's happening?

Dr. FALCON. Battle Creek is a large neuropsychiatric hospital, a rural hospital. It's one of 24 large like hospitals around the country, that experience over the past years a major problem with quality of care issues, with the ability to recruit qualified psychiatrists and the ability to deliver reasonable standards of care, was felt by several outside reviewers. Because of this it was decided to attempt to organize a consultative education intervention between the Ann Arbor VA, the University of Michigan Department of Psychiatry, to attempt to assist them.

This is basically structured to share with them psychiatric expertise with the continuing medical education programs in regularly scheduled patterns, to share consultation over research, academic, and other areas, and to assist them in recruitment. This is not an affiliation agreement. This is a consultative agreement. This is supported by the regional director of the Great Lakes Region, and we are doing this as a 3-year pilot study to see if by design this type of intervention can be effective in improving the quality of care and the ability to recruit physicians in an institution such as this. This is the type of institution that was alluded to earlier in the mortality study in terms of a large neuropsych hospital.

Mr. STEINBERG. Could you describe the status of staffing at Battle Creek in terms of the number of psychiatrists with Board Certification, on the one hand, and the number of foreign medical school graduates on the other?

Dr. FALCON. Currently, as far as I know, and I think I know, there are no psychiatrists who are on staff who are certified by the American Board of Psychiatry and Neurology.

Mr. STEINBERG. How many are Board eligible?

Dr. FALCON. Of the 18—I think there's 18 filled FTE positions within psychiatry service, and probably 12 of those, or 13 of those are Board eligible. They have needed—on the basis that they could not recruit any psychiatrists, even non-Board Certified, they have recruited family practitioners and general practitioners to deliver primary psychiatric care, that have had no training. And there are at least four of these who are responsible for direct psychiatric care.

Mr. **Steinberg**. How many are foreign medical school graduates?

Dr. **Falcon**. I would say that the majority of the Board eligible individuals are foreign medical school graduates. Most, if not all.

Mr. **Steinberg**. Are they non-American foreign medical school graduates?

Dr. **Falcon**. Yes, the majority of them are.

Mr. **Steinberg**. And do they have adequate facility with spoken and written English, in your opinion, to carry out their responsibilities as mental health therapists?

Dr. **Falcon**. I think that there is a distribution of this facility across these individuals and particularly with certain parts of our population, such as the population with PTSD and others, that are reasonably high functioning and are capable of insight, there are some problems with that. It would be hard for me to make a generalization about that, but I would think that there are deficiencies, as you would expect in any group where there was over representation of this particular type of psychiatrist.

Mr. **Steinberg**. Thank you.

We understand that because of the budget shortfall, we have the somewhat anomalous position where some medical centers are actually sending veterans with PTSD or other readjustment problems, who have not been adjudicated service connected, to vet centers for evaluation and care. Do you, as a member of the special committee, have an opinion as to how this referral from medical centers to vet centers is affecting the patient's care, as well as how it's affecting the operations at the vet centers?

Dr. **Falcon**. Yes, I have an opinion on that as well. In a survey that we did looking at who provided the care in medical centers versus vet centers for PTSD, it was found that in the vet centers, less than 1 percent of the care was actually provided by psychiatrists. This is not to say that psychiatrists are the only ones that can provide it, but with many of these individuals, they're quite ill, requiring psychiatric evaluation and frequently stabilizing medication, and things like that. From that standpoint alone, the fact that most of these evaluations now for these less entitled individuals are happening at the vet centers is severely going to compromise the ability to evaluate their condition.

I think that we're going to expect to see more and more of this over the coming year, as there is a tighter availability brought by the budget constraints on our mental hygiene clinics. We just do not have the people in our mental hygiene clinics to provide the services. It is not only the category B and C issue, it is the fact that with the budget constraints and the decrease of staffing to psychiatry services, the people aren't there to make the provision any more.

Mr. **Steinberg**. How about the effect of these kinds of referrals on the operations at the vet centers?

Dr. **Falcon**. Well, I think it could be strangling. As Dr. Blank said, there's about four individuals at each vet center. They're relatively small, and their mission was never designed to provide comprehensive mental health care. Their mission was to do readjustment counseling. And so the idea that much of our work load would be shifted to them is certainly going to be very difficult for them, and it's going to present false hopes to veterans that they will be able to be seen there. They will still be able to be seen in vet centers, even if they can't be seen in medical centers, but in fact, we just do not have the resources in the vet centers to deliver this kind of care.

Mr. **Steinberg**. Dr. Klauck, do you have anything you want to add on that point?

Dr. **Klauck**. Just anecdotal. We do refer veterans between our medical center and the Milwaukee Vet Center, but I think it is a mutual kind of sharing, and sometimes the veteran, I think, prefers to go down to the Vet Center for readjustment counseling.

Mr. **Steinberg**. I take it that you each are familiar with the vet centers that operate in your general vicinity?

Dr. **Falcon**. Yes.

Mr. **Steinberg**. And that each of you have ongoing relationships with them?

Dr. **Falcon**. Yes.

Mr. **Steinberg**. Do you have a view as to the effectiveness of the vet centers in carrying out their readjustment counseling mission?

Dr. **Falcon**. I think they do a very good job. The ones that I have had contact with, both in my local area and through oversight review over the past 5 years that I've been on the special committee, I've been very impressed with the commitment and the level of activity that exists in the vet center to carry out that mission.

Mr. **Steinberg**. How many vet centers would you say that you're familiar with?

Dr. **Falcon**. I have probably personally visited 20 from Alaska to Philadelphia. I've been to a lot of them, and met a lot of different people that work in these vet centers. And I feel that they really take these positions very seriously, and they have a very serious commitment to this population. And I think they do a very good job. But I think that it is specific. Remember, there's no psychiatrists in these vet centers.

Mr. **Steinberg**. I think that was the point that Senator Cranston was trying to make to Senator Murkowski before he had to leave.

Dr. Klauck, do you have any comment on that, on your view of the adequacy of vet centers in performing their readjustment counseling mission?

Dr. **Klauck**. Well, of the ones that I am familiar with, they do an excellent job. And, for example, in Wisconsin, the vet centers were instrumental in getting the State to supplement the fee-for-contract program this past year.

Mr. **Steinberg**. Not an easy task, I imagine.

Dr. **Klauck**. Not an easy task.

Mr. **Steinberg**. Especially in these times of strained budget resources at all levels.

This is a question for each of you. As a clinician, could you tell us whether having a veteran with PTSD go through the adjudication process might in some cases be detrimental to that veteran's course of treatment, and, if so, why it might be difficult from the veteran's point of view to undergo such adjudication prior to treatment?

Do you want to lead off, Dr. Falcon?

Dr. **Falcon**. Yes.

I think that from a clinical standpoint, there are frequently elements of the adjudication that are problematic, particularly the need to prove certain evidence and facts around events, in order to be adjudicated to have PTSD. I think that it is very difficult for patients. And that frequently the purpose, the main purpose of the adjudication, if it is to assure the availability of services, gets lost in the process. It was mentioned earlier, the relatively small number; I think 26,000 individuals that are service connected for PTSD nationally. And I think that this is, in many ways, a reflection of this difficulty that most individuals really don't want to, and can't go through the long and laborious process associated with this, which frequently with appeals and other activities can take well over a year. And frequently, much longer than that.

So I think that from the standpoint of the process of adjudication, that is very difficult, and can be an impediment. From a standpoint of how it is helpful to veterans, it is very helpful if there is an acknowledgment by the Veterans' Administration that, in fact, a veteran has PTSD and is service connected for the PTSD. I think that when this happens, when there is an acknowledgment by the U.S. Government that this has happened, I think that there is a sense, many ways, of truth that is in that. That it isn't present before. And so that is a benefit that does exist and sometimes can be used therapeutically.

Chairman CRANSTON. Dr. Falcon, I have about three more questions. I'd appreciate very brief responses, because I'm getting into a time problem.

Dr. FALCON. OK.

Chairman CRANSTON. Did you have something to add, Dr. Klauck?

Dr. KLAUCK. Well, I was just going to say that in Milwaukee, myself, as well as most of our staff, do conduct compensation examinations, and we do try to make them as nonthreatening as possible. But it is very difficult for veterans to come in and to provide evidence of their stressors. And with the short period of time alotted it is sometimes difficult to get them to provide the evidence of their stressor, and then try to send them on their way. So, it is not exactly the best process from a therapeutic standpoint.

Chairman CRANSTON. Dr. Falcon, as a member of the VA special committee, do you have any opinion as to how important it is for VA to track expenditures for treatment of veterans suffering from PTSD?

Dr. FALCON. I think that it is very important. I think that we have recognized over the last few years that it is really essential to demand accountability out of medical centers, and allocations that are given to them for PTSD. And that tracking like this would be an essential part of that.

Chairman CRANSTON. You heard my exchange with Dr. Gronvall regarding the funding of the National Center on PTSD. As a member of the VA special committee, would you comment on the adequacy of the $1.46 million provided for the past year's operating costs for the new consortium?

Dr. FALCON. Yes, I would. We do feel in discussion both with the new National Center individuals, and among the committee ourselves that this is inadequate. And that it should be reconsidered back to the original request from the National Center group that was given the award of having the National Center. I believe this was $2.2 or $2.4 million, if I'm correct.

Chairman **Cranston**. We're hoping we can get some special supplementals to help on that front.

Dr. **Falcon**. I'm sure they'd really appreciate that. And I think it would make it—you know, we've had a failure of the National Center that has happened in the past. It's really important that there'll be adequate funding of this National Center so that, in fact, we'll be able to be successful this time.

Chairman **Cranston**. What has the special committee already recommended to do in response to the RTI data?

Dr. **Falcon**. Well, we have continued and resupported our recommendations that there be PTSD treatment teams located in every medical center around the country. And that continued analysis of the data happen. And this has been planned and designed for the next couple of years. But that it is clearly evident that we feel that if more money is going to be put into clinical treatment for PTSD, that it should initially be put into PTSD treatment teams. That was one of the original recommendations to the committee in 1985, that they exist around the country. To this date there are 23, as Dr. Gronvall has said. And that we feel that if there's anything that can be done operationally in the present time, that this is the approach that should be taken.

Chairman **Cranston**. So there are actually 15? Fifteen is the actual number, I believe.

Dr. **Falcon**. There are 15 now, and I believe that there will be 23 designated after this week.

Chairman **Cranston**. Thank you both very much. You've been very helpful and we appreciate it.

If the final panel would please come forward now. And I welcome the representatives from the veterans service organizations: Sam Walsh from the Legion, James Magill from the Veterans of Foreign Wars, Dave Gorman from the DAV, Frank DeGeorge from the Paralyzed Veterans, and Tom Sherwood from the Vietnam Veterans of America.

Thank you all for being here. Sam, I'd appreciate it if you would express our condolences to Dick Christian on the death of his father.

Mr. **Walsh**. Thank you, Senator.

Chairman **Cranston**. Dave, let's start with the DAV.

STATEMENT OF DAVID W. GORMAN, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR FOR MEDICAL AFFAIRS, DISABLED AMERICAN VETERANS

Mr. **Gorman**. Thank you, Mr. Chairman. I think there are three issues that I'd like to address orally.

The first being section 201 of S. 13, which has received an extensive amount of testimony today. And as we understand it would direct the VA to furnish medical care on a priority basis to any veteran who served in a combat area and was diagnosed subsequently as suffering from combat-related PTSD.

Although we are supportive of the intent, there are two concerns we would like to see addressed. The first concern is the concept of priority treatment. To attach a priority for care based simply on diagnosis, and not necessarily need, or to place a priority of care simply on the basis of diagnosis alone, may not always represent sound medical practice, on in fact equity to access of care of disabled veterans.

Second, in an era of severe budgetary shortfalls, and known restricted access to VA health care to those veterans who are mandated care, the prospect of expanding eligibility to a certain group of veterans who are not——

Chairman CRANSTON. Dave, can I ask if you got the memo rating in, would you then support the provision——

Mr. GORMAN. I'm sorry?

Chairman CRANSTON. If you got the memo rating procedure into the bill, would you then support it with that provision?

Mr. GORMAN. Most definitely. I think that's an extremely easy way to do it. I think the VA is capable of doing it through the Department of Veterans Benefits. They do it for numerous other issues. And in fact, the medical-care issue is one of those ways. So I think the memorandum rating certainly would gain our support.

Chairman CRANSTON. Thank you.

Mr. GORMAN. The other part of S. 13 that we'd like to discuss is section 204, which would direct the Secretary in conjunction with annual budget submissions to Congress, to identify the amount of appropriations estimated to be obligated for PTSD activities.

Mr. Chairman, there appears to be a crying need for a revision of the entire VA budget formulation methodology. Therefore, the DAV suggests that the principal embodied in section 204 be expanded to include not only PTSD, but the entire broad range of issues and services involved in the Department's budget formulation process. I would note here, Mr. Chairman, that the independent budget addresses this very issue and advocates its inclusion as a part of the VA's budget process.

Mr. Chairman, both your amendment to S. 13 and S. 846 introduced by Senator Murkowski, propose significant improvements in the manner in which the VA would be authorized to provide services to participants in the CWT program. We applaud you and Senator Murkowski for your obvious concern and commitment regarding this program, and also for the extremely innovative approaches taken to accomplish this goal. In both concept and intent, both measures have the full support of the DAV.

The prospect of the VA moving in the direction of transitional housing is exciting and is an exercise the DAV desires to actively participate in. And we eagerly look forward to being an active player in the dialogue and the establishment of the program envisioned by these measures.

Again, Mr. Chairman, we wish to applaud you and Senator Murkowski for the introduction of this innovative and important legislation. And we anxiously await the opportunity to work with the committee, as well as the VA, to achieve a mutually satisfactory and workable transitional housing program.

Finally, Mr. Chairman, the DAV is supportive of both S. 86 and S. 405, both introduced by yourself.

That concludes my oral remarks, Mr. Chairman. Thank you.

[The prepared statement of Mr. Gorman appears on p. 163.]

Chairman CRANSTON. Thank you very much. I appreciate your testimony.

Sam, do you want to proceed next?

STATEMENT OF SAMUEL J. WALSH, ASSISTANT DIRECTOR, NATIONAL LEGISLATIVE COMMISSION, THE AMERICAN LEGION

Mr. WALSH. Thank you, Mr. Chairman. The American Legion has previously appeared before this committee in support of legislative efforts to expand and improve VA's programs of treatment for veterans suffering from PTSD. As highlighted by the recent findings of both The American Legion study and VA's study conducted by Research Triangle Institute, PTSD affects a significant number of combat veterans, as well as veterans who have served in areas where active hostilities were occurring. We strongly believe that certain changes need to be made in the law to improve access to needed treatment programs by veterans who have been diagnosed as suffering from PTSD.

With respect to S. 13 we are supportive of the proposed requirements for additional reports by the special advisory committee over the next 3 years. We are also supportive of a comprehensive study on the evidence of PTSD amongst Asian-Americans, American Indians, Native Hawaiians, and other Native American Pacific Islanders, including American Samoan natives and Alaskan Native Vietnam veterans.

With respect to section 204, The American Legion has a specific mandate on this issue as set forth in a resolution urging the Congress and the administration to provide adequate funding for the continued operation of the PTSD inpatient program, and for the badly needed expansion of the program.

The American Legion supports the intent of the two bills to expand and enhance VA's Compensated Work Therapy Program. Having the flexibility to conduct pilot programs using nonprofit corporations, in-house VA facilities, or private housing, will allow a combination of program models to be studied, and provide greater adaptability for specific geographic locations.

The American Legion is supportive of S. 86 to increase the amount of VA research funding directed toward mental illness and an increase in educational funds and training stipends for academically oriented medical facilities.

Mr. Chairman, The American Legion appreciates the concern expressed for our Nation's homeless veteran population, as exemplified by S. 405. In light of the success of the current pilot, we believe the Homeless Chronically Mentally Ill Program should be made permanent.

Mr. Chairman, the goal of the proposal to link VA's Compensated Work Therapy Program with a new program of therapeutic transitional housing is similar to a program The American Legion Department of Pennsylvania recently inaugurated. We fully support an expansion of the Compensated Work Therapy Program as proposed.

Mr. Chairman, this concludes our summary.

[The prepared statement of Mr. Walsh appears on p. 176.]

Chairman **Cranston**. Thank you very, very much.

Jim.

STATEMENT OF JAMES N. MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. **Magill**. Thank you, sir.

Section 201 of S. 13 requires the VA to furnish post-traumatic stress disorder treatment to a veteran who has served in a theater of combat operations, and whom the VA mental health professional has diagnosed as suffering from service-related PTSD. The VFW supports this provision in light of the fact that current budget shortfalls suffered by the VA has produced a situation where veterans with combat-related PTSD may well be turned away from the treatment at VA hospitals. Often times a veterans' symptoms are not sufficiently overt to allow for a ready diagnosis of PTSD, with a consequent determination of service connection. As VAMC's struggle to contend with their budgetary shortfalls, veterans who are not recognized as category A are more likely than ever to be refused desperately needed care or must wait an inordinate amount of time before receiving such care.

Section 202 would mandate that the VA's Special Committee on PTSD submit to the VA and to the two congressional Veterans' Affairs Committees reports on the prevalence of PTSD among Vietnam veterans. The VFW supports this action.

Section 203 of S. 13 would require the VA to carry out a scientifically valid study of post-war psychological problems, including PTSD among various minority groups. The VFW supports that section.

Section 204 of S. 13 requires the VA to submit, as part of its annual budget documents, detailed information on funds that are estimated to be spent for compensation for PTSD. The VFW also supports this section.

I will now address an amendment to section 212 of S. 13, which is to be offered by the chairman. This amendment would establish a 5-year pilot program to expand and enhance VA compensated work therapy programs. The VFW supports this amendment to section 212.

Next under consideration is S. 192, a bill which would require the Secretary of Veterans Affairs to provide for the conduct of the comprehensive study of the psychological problems of Native Americans who are Vietnam veterans. Our support of this worthy legislative initiative is, of course, in keeping with our already voiced support of section 203 of S. 13. And, of course, we do support that.

The next bill, S. 846, would amend title 38 to improve the compensated work therapy and other services and assistance furnished to homeless veterans and other veterans. In this regard, the VFW has already voiced its support of the chairman's proposed amendment, which would establish a 5-year pilot program to expand and enhance VA compensated work therapy programs.

These two legislative initiatives are similar in intent. We view the particulars of their provisions as being complimentary and should serve to augment one another. Therefore, S. 846 does enjoy the support of the VFW.

Next under consideration is S. 86, a bill to amend title 38, United States Code, to improve the capability of the Department of Veterans Affairs health care to provide the most effective and appropriate service as possible to veterans suffering from mental illness. For those reasons outlined in our written statement, the VFW strongly supports this proposal.

The last bill is S. 405, a bill to require the Department of Veterans Affairs to conduct a program providing community based residential treatments for homeless chronically mentally ill, and to authorize the inclusion of other chronically mentally ill veterans in such a program. The VFW strongly supports S. 405.

This concludes my statement, sir.

[The prepared statement of the Veterans of Foreign Wars of the United States appears on p. 192.]

Chairman CRANSTON. Thank you very much.

Frank.

STATEMENT OF FRANK R. DeGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. DEGEORGE. Thank you, Mr. Chairman. S. 13, section 201 would provide priority inpatient and outpatient mental health services for any veteran suffering from diagnosed post-traumatic stress disorder, who participated in hostilities in World War I, World War II, Korea, Vietnam, or subsequent armed hostilities and military actions. Consistent with our previous positions, Paralyzed Veterans of America strongly supports this provision.

At the present time the Department of Veterans Affairs is curtailing the availability of both inpatient and outpatient services for thousands of veterans, veterans in need of a wide variety of healthcare services, due to the persistent funding shortfall facing the Department. Many of these veterans fall into category B and category C eligibility criteria. However, as we have testified previously, the DVA is also delaying and denying treatment for category A veterans in need of both inpatient and outpatient services. We have sought to at least partially correct this situation by calling for a clear mandatory entitlement for outpatient services for all category A veterans. We urge the committee to, once again, review and adopt this proposal. However, at the same time, we enthusiastically endorse this section of Senate bill 13 which would, at least, create a clear entitlement for mental health treatment for all veterans suffering from this individual disorder, called PTSD.

Section 202, PVA has always found the VA's Special Committee on PTSD to be an important stimulus and an effective advocate for the Department's PTSD programs and services. We support enactment of section 202.

Section 203, this provision is identical to the language of S. 192, introduced by Senator Matsunaga. PVA greatly appreciates the concerns expressed by the Senator in drafting this bill and bringing this matter to the attention of the committee. PVA, too, is concerned that the National Vietnam Veterans Readjustment Study authorized by public law did not specifically address the readjustment status of Native Americans in the Continental United States, Alaska, Hawaii, and the Pacific Islands. The study did, however, reveal that veterans in all minority groups continue to suffer readjustment problems in higher degrees than their veteran counterparts in the rest of the Vietnam veteran population. From what we understand from anecdotal evidence, this finding can also be extrapolated to the populations that are identified in this provision.

The DVA should move immediately to address this problem. A study in the nature of the proposal contained in this section and in S. 192 could provide important corroborative data. However, we understand the approximate cost of conducting such a study would be in excess of $1 million and would take at least 1 year, if not 2 to 3 years to design, implement, and evaluate. We believe that the investment placed in this study, both in manpower time and dollars, could be far better expended in providing immediate and direct services to meet the needs of this veteran population. We also believe that important statistical information on the readjustment status of these veterans could be derived from the patient treatment files once additional outreach counseling and services were provided to these patient populations. At the same time, these veterans would be receiving more immediate assistance now, rather than having to wait until the proposed study itself is completed later.

PVA supports enactment of section 205 to provide funding for PTSD programs.

As it pertains to S. 86, PVA finds the MIRECC concept laudable; however, we would suggest that prior to authorization and implementation of this program, the committee make certain that all preexisting funding commitments to similarly functioning research and education programs, including the so-called SCI GRECC, are fully met.

Mr. Chairman, I would conclude my statement at this time, and thank you very much for the opportunity to be here.

[The prepared statement of Mr. DeGeorge appears on p. 202.]

Chairman CRANSTON. Thank you a great deal.

Tom.

STATEMENT OF THOMAS A. SHERWOOD, DIRECTOR OF HEALTH POLICY AND PLANNING, VIETNAM VETERANS OF AMERICA

Mr. SHERWOOD. Thank you, Mr. Chairman.

As the written testimony indicates, the overriding issue is availability of resources and quality assurance. The question is, when will the DVA mental health delivery system get the resources to do the job relative to its work load. It is as if the DVA is unable to determine the true relative meaning and mission in the total health-care scheme, when one views the beating mental health takes regarding the distribution of DVA health-care dollars.

As our written testimony indicates, we have many concerns regarding what is happening to veterans in DVA mental health care. The issue of dual diagnosis needs to be addressed as clinical policy. The treating of the veteran who has a substance abuse problem, PTSD, and alcoholism as if he were three different people instead of one person with multiple afflictions, is not likely to be beneficiary to that veteran. Such treatment may protect and preserve medical fiefdoms, but it is not likely to be helpful to the patient. Because such practices are institution in the larger medical world, the DVA is not excluded from acting in the interest of the veteran it serves.

Regarding S. 13, section 204, funding PTSD, VA recognizes the need to hold the DVA accountable for PTSD care in terms of tracking its expenditures for such programs. We are aware that DVA has cut its contractual services budget by one-half, or as much as $2.5 million in attempt to protect DAV noncontract readjusting counseling program operations. However, sometimes these cuts are made with little warning to community or providers for those services. This, in turn, completely interferes with the continuity of services to the veteran, in addition to ruining all credibility and trust these community providers may have for the DVA and for the American Government.

As a result, the providers, out of compassion for the veteran, continue to provide these services at their own expense. I don't think this is a way to treat veterans. VVA supports the concept of the MIRECCs, but with the expectation that they will be fully supported in terms of staffing, resources, collateral systems, medical center and Department of Veterans Benefits support. Further, these centers, like GRECCs, should be affiliated with appropriate schools of medicine and other allied professional institutions involved in mental health. However, these affiliations must be driven primarily by the veterans clinical needs followed and supported by the need of staff for research and educational activities in the client's clinical interest.

In conclusion, as our testimony indicates, we support many of the legislative initiatives heard at this hearing today. We have indicated the need to address issues relative to incarcerated vets, DGRs and mental health-care costs, and the need to avail the veteran diagnosed with PTSD presumptive service connected for both health and benefits, and the importance of the recommendations of the Chief Medical Director's Special Committee on PTSD.

Thank you very much.

[The prepared statement of Mr. Sherwood appears on p. 214.]

Chairman CRANSTON. Thank you very, very much. I appreciate the testimony of all five of you. I appreciate also your brevity. And any full statements will, of course, go in the record as read.

I want to thank the Legion, the PVA, the VFW, and the VVA for their support of, and DVA for its qualified support of section 201 regarding the PTSD priority care.

I also want to thank you, John, and the other VA witnesses, for remaining throughout the hearing. I think it's important that you hear what others have to say about the VA programs and issues. And your patience and cooperation are much appreciated.

The hearing is now adjourned. Our next hearing is next week, Thursday, June 22. Thank you all very much.

[Whereupon, at 11:51 a.m., the committee was adjourned, to reconvene at the call of the Chair.]

APPENDIX

II

101st CONGRESS
1st Session

S. 13

To amend title 38, United States Code, to increase the rates of disability compensation and dependency and indemnity compensation for veterans and survivors, to increase the allowances paid to disabled veterans pursuing rehabilitation programs and to the dependents and survivors of certain disabled veterans pursuing programs of education, and to improve various programs of benefits and health-care services for veterans; and for other purposes.

IN THE SENATE OF THE UNITED STATES

January 25 (legislative day, January 3), 1989

Mr. Cranston (for himself, Mr. Matsunaga, Mr. DeConcini, and Mr. Rockefeller) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to increase the rates of disability compensation and dependency and indemnity compensation for veterans and survivors, to increase the allowances paid to disabled veterans pursuing rehabilitation programs and to the dependents and survivors of certain disabled veterans pursuing programs of education, and to improve various programs of benefits and health-care services for veterans; and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Benefits and Health Care Act of 1989".

SEC. 2. REFERENCE TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

TITLE II—HEALTH CARE

PART A—PROGRAMS RELATING TO POST-TRAUMATIC STRESS DISORDER AND MENTAL HEALTH

SEC. 201. CARE FOR COMBAT VETERANS WITH SERVICE-RELATED POST-TRAUMATIC STRESS DISORDER.

(a) IN GENERAL.—Section 602 is amended—

(1) by inserting "(a)" before "For"; and

(2) by adding at the end the following new subsections:

"(b) Any veteran—

"(1) who served on active duty in a theater of combat operations (as defined in regulations prescribed by the Secretary) during World War I, World War II, the Korean conflict, or the Vietnam Era or in any other area during a period in which hostilities (as defined in subsection (c) of this section) occurred in such area, and

"(2) whom a mental health professional designated by the Chief Medical Director has diagnosed, following an examination of such veteran by such professional, to be suffering from post-traumatic stress disorder related to such service,

shall be furnished care and services for such disorder pursuant to sections 610(a)(1)(A) and 612(a)(1)(A) of this title even though such disorder has not been determined to be service-connected.

"(c) For the purposes of subsection (b) of this section, the term 'hostilities' means an armed conflict in which members of the Armed Forces are subjected to danger comparable to the danger to which members of the Armed Forces have been subjected in combat with enemy armed forces during a period of war, as determined by the Secretary in consultation with the Secretary of Defense.".

(b) CLERICAL AMENDMENTS.—(1) The heading of such section is amended to read as follows:

"§ 602. Special provisions relating to mental illness disabilities".

(2) The item relating to such section in the table of sections at the beginning of chapter 17 is amended to read as follows:

"602. Special provisions relating to mental illness disabilities.".

SEC. 202. SPECIAL COMMITTEE ON POST-TRAUMATIC STRESS DISORDER.

(a) Evaluation of Study of Postwar Psychological Problems of Vietnam Veterans.—(1) Not later than June 1, 1989, the Special Committee on Post-Traumatic Stress Disorder (hereinafter in this section referred to as the "Special Committee") established pursuant to section 110(b)(1) of the Veterans' Health Care Act of 1984 (Public Law 98–528; 98 Stat. 2691) shall submit concurrently to the Secretary of Veterans Affairs and the Committees on Veterans' Affairs of the Senate and the House of Representatives (hereinafter in this section referred to as the "Committees") a report setting forth the Special Committee's evaluation of the results of the study required by section 102 of the Veterans' Health Care Amendments of 1983 (Public Law 98–160; 97 Stat. 994). Such report shall include the Special Committee's—

(A) overall evaluation of the conduct, validity, and meaning of the study;

(B) assessment of the capability of the Department of Veterans Affairs to meet the need for the diagnosis and treatment of post-traumatic stress disorder of veterans, and other psychological problems of veterans in readjusting to civilian life, as estimated in the results of such study;

(C) evaluation of the Secretary's report on the study; and

(D) recommendations for any further or follow-up research on the matters addressed in the study.

(2) Not later than 30 days after receiving the Special Committee's report under paragraph (1), the Secretary shall submit to the Committees any comments concerning the report that the Secretary considers appropriate.

(b) UPDATES OF REPORTS UNDER SECTION 110(c) OF PUBLIC LAW 98–528.—(1) Not later than February 1 of each of 1991 and 1992, the Special Committee shall concurrently submit to the Secretary and the Committees a report containing information updating the reports submitted to the Secretary under section 110(e) of the Veterans' Health Care Act of 1984 (Public Law 98–528; 98 Stat. 2693), together with any additional information the Special Committee considers appropriate regarding the overall efforts of the Department of Veterans Affairs to meet the needs of veterans with post-traumatic stress disorder and other psychological problems in readjusting to civilian life.

(2) Not later than 60 days after receiving each of the Special Committee's reports under paragraph (1), the Secretary shall submit to the Committees any comments concerning the report that the Secretary considers appropriate.

SEC. 203. STUDY OF PSYCHOLOGICAL PROBLEMS AMONG ASIAN-AMERICAN, AMERICAN-INDIAN, NATIVE-HAWAIIAN, OTHER NATIVE-AMERICAN PACIFIC ISLANDER (INCLUDING AMERICAN SAMOAN NATIVE), AND ALASKA NATIVE VIETNAM VETERANS.

(a) STUDY REQUIREMENT.—The Secretary of Veterans Affairs shall provide for the conduct of a comprehensive study of the following matters:

(1) The prevalence and incidence in the populations of Asian-American, American-Indian, Native-Hawaiian, other Native-American Pacific Islander (including American Samoan Native), and Alaska Native Vietnam veterans of post-traumatic stress disorder; and other psychological problems experienced by such veterans in readjusting to civilian life.

(2) The effects of such disorder and such problems on such veterans.

The Secretary shall provide for particular attention to be devoted in the conduct of the study to veterans who have service-connected disabilities and to women veterans.

(b) REPORT.—Not later than October 1, 1991, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing the results of the study required by subsection (a).

(c) DEFINITIONS.—In this section:

(1) The terms "veteran", "service-connected", and "Vietnam veteran" shall have the same meanings given those terms in section 102(c) of the Veterans' Health Care Amendments of 1983 (Public Law 98–160; 38 U.S.C. 612A note).

(2) The term "Alaska Native" has the meaning given the term "Native" in section 3(b) of the Alaska Native Claims Settlement Act (43 U.S.C. 1602(b)).

(3) The term "Native Hawaiian" has the meaning given that term in section 813(3) of the Native American Programs Act of 1974 (42 U.S.C. 2992c(3)).

SEC. 204. FUNDING FOR POST-TRAUMATIC STRESS DISORDER PROGRAMS.

In the documents providing detailed information on the budget for the Department of Veterans Affairs that the Secretary of Veterans Affairs submits to the Congress in conjunction with the President's budget submission for each fiscal year beginning after fiscal year 1990 pursuant to section 1105 of title 31, United States Code, the Secretary shall identify the amounts in the appropriations requests for Department accounts that are estimated to be obligated for—

(1) the payment of compensation to veterans for disabilities resulting from post-traumatic stress disorder (hereinafter in this section referred to as "PTSD") that is service-connected;

(2) the treatment of veterans by or at the expense of the Department for PTSD related to their active-duty service, including specific designation of funds for the treatment of PTSD—

(A) in PTSD programs designated pursuant to section 110(a)(1) of Public Law 98–528;

(B) in inpatient psychiatric programs and outpatient mental health programs other than such designated PTSD programs;

(C) in readjustment counseling programs pursuant to 612A of title 38, United States Code; and

(D) under contract through non-Department providers of (i) readjustment counseling services pursuant to section 612A(e) of such title, (ii) mental health services pursuant to such section 612A(e), or (iii) mental health services pursuant to other authority, and described in the first annual report submitted pursuant to section 110(e)(1) of Public Law 98–528 as having been proposed by the Special Committee on Post-Traumatic Stress Disorder;

(3) education, training, and research at—

(A) the National Center on Post-Traumatic Stress Disorder established under section 110(c) of Public Law 98–528;

(B) any centers of mental illness research, education, and clinical activities that may be established at Department medical centers; and

(C) other Department research facilities; and

(4) the operation of the National Center on Post-Traumatic Stress Disorder.

VETERANS BENEFITS AND HEALTH CARE ACT

CRANSTON (AND OTHERS) AMENDMENT NO. 124

(Ordered referred to the Committee on Veterans' Affairs.)

Mr. CRANSTON (for himself, Mr. MATSUNAGA, Mr. DECONCINI, Mr. MITCHELL, Mr. ROCKEFELLER, and Mr. GRAHAM) submitted an amendment intended to be proposed to the bill (S. 13) to amend title 38, United States Code, to increase the rates of disability compensation and dependency and indemnity compensation for veterans and survivors, to increase the allowances paid to disabled veterans pursuing rehabilitation programs and to the dependents and survivors of certain disabled veterans pursuing programs of education, and to improve various programs of benefits and health-care services for veterans; and for other purposes, as follows:

On page 19, strike out lines 8 through 21 and insert in lieu thereof the following:

SEC. 212. COMPENSATED WORK THERAPY PROGRAM.

(a) AUTHORIZED SOURCES FOR PROVISION OF THERAPEUTIC WORK.—Subsection (b)(1) of section 618 is amended by striking out "contractual arrangements with private industry or other sources outside the Veterans' Administration" and inserting in lieu thereof "a contract or other arrangement with any appropriate source (whether or not an element of the Department of Veterans Affairs or of any other Federal entity)".

(b) USE OF REVOLVING FUND.—The first sentence of subsection (c)(1) of such section is amended by inserting before the period at the end "(including defraying the costs of travel and related expenses necessary to train employees in the administration of services under such subsection)".

(c) PILOT PROGRAM.—Section 618 is amended by adding at the end the following new subsection:

"(g)(1) During fiscal years 1990-1994, the Secretary shall conduct a pilot program to encourage and participate in the establishment of nonprofit corporations for the purpose of contracting with such nonprofit corporations to conduct compensated work therapy programs at Department of Veterans Affairs medical centers operating such programs.

"(2) The Secretary may enter into not more than 25 contracts with nonprofit corporations under the pilot program.

"(3) The Secretary may enter into a contract with a nonprofit corporation under the pilot program only if the corporation provides assurances satisfactory to the Secretary that it will operate a therapeutic residence for eligible veterans in connection with an existing compensated work therapy program at the medical center involved. The contract may remain in effect only as long as the corporation operates such a therapeutic residence for eligible veterans in connection with the pilot program.

"(4) A contract with a nonprofit corporation under this subsection may provide for the Secretary, as partial payment under the contract, to furnish the corporation inkind services, including—

"(A) technical and clinical advice;

"(B) supervision of the activities of compensated work therapy participants in the rehabilitation of any property for use as a therapeutic residence under the contract and for possible later sale as a private residence; and

"(C) minor maintenance of and minor repairs to such a therapeutic residence.

"(5)(A) In order to assist a nonprofit corporation to purchase or lease any real property for the purpose of operating a therapeutic residence under the pilot program, the Secretary may—

"(i) make advance payments to the corporation;

"(ii) lend the corporation up to the maximum amount specified in subparagraph (D) of this subsection; or

"(iii) both.

"(B) Advance payments and loans authorized by this paragraph may be paid out of sums in the fund.

"(C) Sums received by a nonprofit corporation as advance payments or loans pursuant to this paragraph may be used only for the purchase or lease of real property for use as a therapeutic residence pursuant to the pilot program, except that advance payments may also be used for the operation of such a residence.

"(D) The amount of a loan under this subsection may not exceed—

"(i) in the case of a purchase of real property for such use, the amount equal to 25 percent of the purchase price; or

"(ii) in the case of a lease of real property for such use, the amount of the rent for one year.

"(E) A loan made to a nonprofit corporation under this paragraph shall be repaid within five years after the date on which the nonprofit corporation first accepts eligible veterans to reside in a therapeutic residence purchased or leased with the funds loaned to the corporation.

"(6) In the case of each nonprofit corporation to which an advance payment or loan is made under paragraph (5) of this subsection for the purchase of real property, the pilot program contract with such corporation shall include a provision that requires the corporation—

"(A) to sell the real property if the corporation does not operate or ceases to operate a therapeutic residence on that property.

"(B) in the case of an advance payment or advance payments, to pay the fund the amount equal to the excess, if any, of the total amount advanced to the corporation over the amount of the accrued obligation of the Department of Veterans' Affairs to the corporation under the contract;

"(C) in the case of a loan, to pay the fund the sum of the unpaid balance of the loan and the amount equal to 50 percent of the excess, if any, of the sale price over the total amount paid by the corporation for the purchase and improvement of such real property; and

"(D) to use the proceeds of the sale of the property to pay, to the extent of the proceeds, the obligations imposed by clauses (B) and (C) of this paragraph.

"(7)(A) The Secretary shall deposit in escrow any sums to be advanced or loaned to a nonprofit corporation by the Department of Veterans Affairs under paragraph (5) of this subsection until the corporation demonstrates to the satisfaction of the Secretary that at least 25 percent of the net annual operating expenses of the corporation will be paid out of funds obtained from sources other than the Department of Veterans Affairs or will be satisfied by in-kind services obtained from such sources, or both. For the purpose of this subparagraph, the term 'net annual operating expenses' means the amount equal to the excess of the estimates amount of the annual expenses of operating the therapeutic residence or therapeutic residences to be acquired or operated with such escrow sums ovr the estimated annual rental income from eligible veterans residing in such residence or residences.

"(B) If, in the case of a corporation for which any amount is held in escrow pursuant to subparagraph (A) of this paragraph in connection with a contract awarded under the pilot program, the corporation fails to meet the requirements of such subparagraph within 18 months after the award of that contract, the corporation shall forfeit all rights to the amount so held in escrow, the escrow shall be terminated, and that amount shall be credited to the fund.

"(8) The Secretary may transfer to the fund from the General Post Fund of a Department of Veterans Affairs medical center benefiting from the operation of a therapeutic residence by a nonprofit corporation in connection with the pilot program such amount as the Secretary considers necessary to make any advance payments and loans to such corporation under subparagraph (5) of this subsection.

"(9)(A) Subject to subparagraph (B) of this paragraph, the Secretary shall transfer to the Veterans Health Services and Research Administration not less than 10 residences acquired by the Department of Veterans Affairs in the administration of chapter 37 of this title.

"(B) Each property so transferred under this paragraph—

"(i) shall be located in an area suitable for meeting the need of the Department for a therapeutic residence under the pilot program; and

"(ii) shall be leased, in accordance with subparagraph (C) of this paragraph, to a nonprofit corporation for operation as a therapeutic residence under the pilot program.

"(C) A lease of property under this paragraph shall—

"(i) provide for a lease period of not less than one and not more than three years and may include one or more options for renewal at the option of both parties for up to three additional years;

"(ii) require that the property be operated as a therapeutic residence during the lease period;

"(iii) require the lessee to pay to the medical center benefiting from the operation of such therapeutic residence 60 percent of the rent received each month during the lease period from eligible veterans residing in a therapeutic residence on such property.

"(iv) provide for return of the property to the Secretary upon termination of the lease; and

"(v) include such other terms and conditions, consistent with this subsection, as the Secretary considers appropriate for protection of the interests of the United States.

"(10) The director of a medical center shall hold the sums received pursuant to paragraph (9)(C)(iii) of this subsection until such sums are transferred pursuant to this paragraph. The Secretary shall periodically transfer such sums to the Loan Guaranty Revolving Fund established by section 1824 of this title. The Secretary, in consultation with the Secretary of the Treasury, shall prescribe regulations to carry out this paragraph.

"(11) In the case of a nonprofit corporation that, on September 30, 1989, is conducting a compensated work therapy program pursuant to a contract awarded by the Department of Veterans Affairs, the operations of such corporation not covered by a contract awarded under the pilot program shall not be affected by the provisions of this subsection.

"(12) In-kind services furnished to a nonprofit corporation by the Department of Veterans Affairs under the pilot program shall be considered as part of a pass-through account under the Department's resource allocation methodology.

"(13)(A) Any nonprofit corporation established to operate a therapeutic residence or therapeutic residences under the pilot program shall be established in accordance with the nonprofit corporation laws of the State or States in which the therapeutic residence or residences are to be operated and shall, to the extent not inconsistent with any Federal law, be subject to the laws of such State or States, as the case may be.

"(B) A nonprofit corporation participating in the pilot program shall be established solely for the purpose of conducting one or more compensated work therapy programs and operating therapeutic residences in conjunction with such programs.

"(C) Except as otherwise provided in this paragraph or under regulations prescribed by the Secretary, a nonprofit corporation participating in the pilot program, and its directors and employees, shall be required to comply only with those Federal laws, regulations, and executive orders and directives which apply generally to private nonprofit corporations.

"(D) The board of directors of each nonprofit corporation participating in the pilot program shall include employees of the Department, but the total number of such employees on the board must be less than one-half of the total number of directors. An employee of the Department of Veterans Affairs directly responsible for the conduct of compensated work therapy programs at the medical center benefiting from the operation of a therapeutic residence by the corporation shall be a member of the board.

"(E) A nonprofit corporation participating in the pilot program may—

"(i) accept gifts and grants from, and enter into contracts with, individuals and public and private entities solely to carry out the purpose specified in subparagraph (B) of this subsection;

"(ii) employ such employees as it considers necessary for such purpose and fix the compensation of such employees; and

"(iii) in the discretion of the corporation board of directors, transfer gifts and grants accepted under clause (i) of this subparagraph to the fund.

"(F) The records of a nonprofit corporation participating in the pilot program shall be available to the Secretary.

"(G) For the purposes of sections 4(a)(1) and 6(a)(1) of the Inspector General Act of 1978, the programs and operations of such a nonprofit corporation shall be considered to be programs and operations of the Department with respect to which the Inspector General of the Department has responsibilities under such Act.

"(H) Such a nonprofit corporation shall be considered an agency for the purposes of section 716 of title 31 (relating to availability of information and inspection of records by the Comptroller General).

"(I) Each such nonprofit corporation shall submit to the Secretary an annual report providing a detailed statement of its operations, activities, and accomplishments during that year. The corporation shall obtain a report of independent auditors concerning the receipts and expenditures of funds by the corporation during that year and shall include that report in the corporation's report to the Secretary for that year.

"(J) Each member of the board of directors of a non-profit corporation participating in the pilot program, each employee of such a corporation, and each employee of the Department involved in the functions of the corporation during any year—

"(i) shall, with respect to such functions, be subject to Federal laws and regulations applicable to Federal employees with respect to conflicts of interest in the performance of official functions; and

"(ii) shall, with respect to such functions, submit to the Secretary an annual statement signed by the director or employee certifying that the director or employee is aware of, and has complied with, such laws and regulations in the same manner as is required of Federal employees.

"(K) The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives an annual report on the number and locations of nonprofit corporations participating in the pilot program and the amount paid by the Secretary to each such corporation under the pilot program.

"(12) Not later than February 1, 1994, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience under the pilot program. The report shall include such recommendations as the Secretary considers appropriate.

"(13) For the purposes of this subsection—

"(A) the term 'nonprofit corporation' means a corporation recognized as an entity the income of which is exempt from taxation under section 501(c)(3) of the Internal Revenue Code of 1986;

"(B) the term 'eligible veteran' means a veteran eligible to receive therapeutic and rehabilitative services under this section;

"(C) the term 'therapeutic residence' means a residential facility in which eligible veterans may reside while participating in a compensated work therapy program conducted pursuant to this section and includes real property associated with such facility; and

"(D) the term 'existing compensated work therapy program' means a compensated work therapy program that is being conducted under this section by a Department of Veterans Affairs medical center on the date of the enactment of the Veterans Benefits and Health Care Act of 1989.".

II

101ST CONGRESS
1ST SESSION

S. 86

To amend title 38, United States Code, to improve the capability of Department of Veterans' Affairs health-care facilities to provide the most effective and appropriate services possible to veterans suffering from mental illness, especially conditions which are service-related, through the designation of up to five of its facilities as centers of mental illness research, education, and clinical activities and for other purposes.

IN THE SENATE OF THE UNITED STATES

JANUARY 25 (legislative day, JANUARY 3), 1989

Mr. CRANSTON (on behalf of Mr. MURKOWSKI, Mr. MATSUNAGA, Mr. DECONCINI, Mr. ROCKEFELLER, and Mr. GRAHAM) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to improve the capability of Department of Veterans' Affairs health-care facilities to provide the most effective and appropriate services possible to veterans suffering from mental illness, especially conditions which are service-related, through the designation of up to five of its facilities as centers of mental illness research, education, and clinical activities and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. MENTAL ILLNESS RESEARCH, EDUCATION, AND CLINICAL CENTERS.

Section 4101 of title 38, United States Code, is amended by adding at the end the following new subsection:

"(g)(1) The purposes of this subsection are (A) to improve and expand the capability of the Department of Veterans' Affairs health-care facilities to respond with the most effective and appropriate services possible to the needs of veterans suffering from mental illness, especially from service-related conditions, and (B) to advance scientific knowledge regarding mental illness, especially service-related conditions, and regarding such needs and the methods of meeting them by facilitating higher quality care for eligible veterans suffering from mental illness, especially from service-related conditions, through research, the education and training of health personnel in the provision of health care to such veterans, and the development of improved models of clinical services for eligible veterans suffering from mental illness.

"(2)(A) In order to carry out the purposes of this subsection, the Secretary, upon the recommendation of the Chief Medical Director and pursuant to the provisions of this subsection, shall designate not more than five health-care facilities of the Department of Veterans' Affairs (at least one of which shall be designated before July 1, 1990) as the locations for centers of mental illness research, education, and clinical activities and (subject to the appropriation of sufficient funds for such purpose) shall establish and operate such centers at such locations in accordance with this subsection.

"(B) In designating facilities as the locations for centers under subparagraph (A) of this paragraph, the Secretary, upon the recommendation of the Chief Medical Director, shall ensure appropriate geographic distribution of such facilities.

"(C) The Secretary may not designate any health-care facility as a location for a center under subparagraph (A) of this paragraph unless the Secretary, upon the recommendation of the Chief Medical Director, determines that the facility has (or may reasonably be anticipated to develop)—

"(i) with an accredited medical school which provides education and training in psychiatry and with which such facility is affiliated, an arrangement under which residents receive education and training in psychiatry through regular rotation through such center so as to provide such residents with training in the diagnosis and treatment of mental illness;

"(ii) with an accredited graduate school of psychology which provides education and training in clinical or counseling psychology or both and with which the facility is affiliated, an arrangement under which students receive education and training in clinical or counseling psychology or both through regular rotation through such center so as to provide such students with training in the diagnosis and treatment of mental illness;

"(iii) an arrangement under which nursing, social work, or other allied health personnel receive training and education in mental health care through regular rotation through such facility;

"(iv) the ability to attract the participation of scientists who are capable of ingenuity and creativity in research into the causes, treatment, and prevention of mental illness and into models for furnishing care and treatment to veterans suffering from mental illness;

"(v) a policymaking advisory committee composed of appropriate mental health care and research representatives of the facility and of the affiliated school or schools to advise the directors of such facility and such center on policy matters pertaining to the activities of such center during the period of the operation of such center; and

"(vi) the capability to conduct effectively evaluations of the activities of such center.

"(3) There are authorized to be appropriated for the basic support of the research and education and training activities of the centers established pursuant to paragraph (1) of this subsection $3,125,000 for fiscal year 1990 and $6,250,000 for each of the next three fiscal years. The Chief

Medical Director shall allocate to such centers from other funds appropriated generally for the Department of Veterans' Affairs medical care account and medical and prosthetics research account such amounts as the Chief Medical Director determines appropriate.

"(4) Activities of clinical and scientific investigation at each center shall be eligible to compete for the award of funding from funds appropriated for the Department of Veterans' Affairs medical and prosthetics research account and shall receive priority in the award of funding from such account insofar as funds are awarded to projects for mental illness.

"(5) The Chief Medical Director shall ensure that research activities carried out through such centers include an appropriate emphasis on the psychosocial dimension of mental illness and on models for furnishing care and treatment to veterans suffering from mental illness.

"(6) The Chief Medical Director shall ensure that useful information produced by the research, education, and training, and clinical activities of such centers is disseminated throughout the Veterans' Health Services and Research Administration through the development of programs of continuing medical and related education provided through regional medical education centers under subchapter II of chapter 73 and other means.

"(7) The official within the Central Office of the Veterans' Health Services and Research Administration responsible for mental health and behavioral sciences matters shall be responsible for the supervision of the operation of the centers established pursuant to paragraph (1) of this subsection.".

SEC. 2. REPORTS.

Not later than February 1 of each of 1991, 1992, and 1993, the Secretary of Veterans' Affairs shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience during the prior fiscal year under the centers established pursuant to the amendment made by subsection (a). Each such report shall contain—

(1) descriptions of (A) activities carried out at each center and the funding provided for such activities, (B) the advances made at each center in research, education and training, and clinical activities, and (C) the efforts to disseminate throughout the Veterans' Health Services and Research Administration useful information produced by such activities; and

(2) the Secretary's evaluations of the effectiveness of the centers in fulfilling the purposes of subsection (g) of section 4101 of title 38, United States Code, as added by subsection (a).

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II

101st CONGRESS
1st Session

S. 192

To require the Secretary of Veterans' Affairs to provide for the conduct of a comprehensive study of the psychological problems of Native Americans who are Vietnam veterans.

IN THE SENATE OF THE UNITED STATES

JANUARY 25 (legislative day, JANUARY 3), 1989

Mr. MATSUNAGA (for himself, Mr. INOUYE, and Mr. CRANSTON) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To require the Secretary of Veterans' Affairs to provide for the conduct of a comprehensive study of the psychological problems of Native Americans who are Vietnam veterans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. STUDY OF PSYCHOLOGICAL PROBLEMS AMONG ASIAN-AMERICAN, AMERICAN-INDIAN, NATIVE-HAWAIIAN, OTHER NATIVE-AMERICAN PACIFIC ISLANDER (INCLUDING AMERICAN SAMOAN NATIVE), AND ALASKA NATIVE VIETNAM VETERANS.

(a) STUDY REQUIREMENT.—The Secretary of Veterans Affairs shall provide for the conduct of a comprehensive study of the following matters:

(1) The prevalence and incidence of the following psychological problems in the populations of Asian-American, American-Indian, Native-Hawaiian, other Native-American Pacific Islander (including American Samoan Native), and Alaska Native Vietnam veterans:

(A) Post-traumatic stress disorder.

(B) Other psychological problems experienced by such veterans in readjusting to civilian life.

(2) The effects of such disorder and such problems on such veterans.

The Secretary shall provide for particular attention to be devoted in the conduct of the study to veterans who have service-connected disabilities and to women veterans.

(b) REPORT.—Not later than October 1, 1991, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing the results of the study required by subsection (a).

(c) DEFINITIONS.—In this section:

(1) The terms "veteran", "service-connected", and "Vietnam veteran" shall have the same meanings given such terms in section 102(c) of the Veterans' Health Care Amendments of 1983 (Public Law 98-160; 38 U.S.C. 612A note).

(2) The term "Alaska Native" has the meaning given the term "Native" in section 3(b) of the Alaska Native Claims Settlement Act (43 U.S.C. 1602(b)).

(3) The term "Native Hawaiian" has the meaning given that term in section 813(3) of the Native American Programs Act of 1974 (42 U.S.C. 2992c(3)).

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II

101st CONGRESS
1st Session

S. 405

To amend title 38, United States Code, to require the Department of Veterans' Affairs to conduct a program providing community-based residential treatment for homeless chronically mentally ill veterans and to authorize the inclusion of certain other chronically mentally ill veterans in such program, and for other purposes.

IN THE SENATE OF THE UNITED STATES

February 9 (legislative day, January 3), 1989

Mr. Cranston (for himself, Mr. DeConcini, and Mr. Matsunaga) introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to require the Department of Veterans' Affairs to conduct a program providing community-based residential treatment for homeless chronically mentally ill veterans and to authorize the inclusion of certain other chronically mentally ill veterans in such program, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. COMMUNITY-BASED RESIDENTIAL CARE FOR HOMELESS AND CERTAIN OTHER CHRONICALLY MENTALLY ILL VETERANS.

(a) IN GENERAL.—Chapter 17 of title 38, United States Code, is amended by adding at the end the following new section:

"§ 620C. Community-based residential care for homeless and other chronically mentally ill veterans.

"(a)(1) The Secretary shall conduct a program to furnish care and treatment and rehabilitative services (directly or by contract) in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities to homeless veterans suffering from chronic mental illness disabilities who are eligible for care under section 610(a)(1) of this title.

"(2) As part of the program, the Secretary may also provide such care and treatment and rehabilitative services—

"(A) to veterans with service-connected chronic mental illness disabilities;

"(B) veterans described in section 612(a)(1)(B) of this title who have chronic mental illness disabilities; and

"(C) veterans being furnished hospital or nursing home care by the Secretary for chronic mental illness disabilities.

"(b) Before furnishing care and treatment and rehabilitative services by contract under subsection (a)(1) of this section to a veteran through a facility described in such subsection, the Secretary shall approve (in accordance with criteria which the Secretary shall prescribe) the quality and effectiveness of the program operated by such facility for the purpose for which the veteran is to be furnished such care and services.

"(c) The Secretary may provide inkind assistance (through the services of Department of Veterans' Affairs employees and the sharing of other Department resources) to a non-Department facility described in subsection (a)(1) of this section which is furnishing care and services to veterans under this section. Any such inkind assistance shall be provided under a contract between the Department and such facility. The Secretary may provide such assistance only for use solely in the furnishing of appropriate care and services under this subsection and only if, under such contract, the Department receives reimbursement for the full cost of such assistance, including the cost of services and supplies and normal depreciation and amortization of equipment. Such reimbursement may be made by reduction in the charges to the United States or by payment to the United States. Any funds received through such reimbursement shall be credited to funds allotted to the Department facility that provided the assistance.

"(d) The Secretary may not furnish care and treatment and rehabilitative services under subsection (a) of this section after September 30, 1992.

"(e) Not later than February 1, 1992, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report on the experience of the Department under this section and the recommendation of the Secretary (together with the reasons for such recommendation) as to whether the program should be continued.

"(f) The authority of the Secretary to enter into contracts under this section shall be effective for any fiscal year only to such extent or in such amounts as are provided in appropriation Acts.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by inserting after the item relating to section 620B the following new item:

"620C. Community-based residential care for homeless and other chronically mentally ill veterans.".

SEC. 2. CONFORMING AMENDMENT.

Section 801(c) of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988 (Public Law 100–628; 102 Stat. 3257) is amended by striking out "section 115 of the Veterans Benefits and Services Act of 1988 (Public Law 100–322, 102 Stat. 501)" and inserting in lieu thereof "section 620C of title 38, United States Code,".

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II

101st CONGRESS
1st Session

S. 846

To amend title 38, United States Code, to improve the compensated work therapy and other services and assistance furnished to homeless veterans and other veterans.

IN THE SENATE OF THE UNITED STATES

April 19 (legislative day, January 3), 1989

Mr. Murkowski introduced the following bill; which was read twice and referred to the Committee on Veterans' Affairs

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A BILL

To amend title 38, United States Code, to improve the compensated work therapy and other services and assistance furnished to homeless veterans and other veterans.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the "Veterans Compensated Work Therapy Program Improvements Act of 1989".

SEC. 2. REFERENCE TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal is expressed in terms of an amendment to, or repeal of, a section or other provision, the reference shall be considered to be made to a section or other provision of title 38, United States Code.

SEC. 3. EXTENSION OF PILOT PROGRAM OF COMMUNITY-BASED CARE FOR HOMELESS CHRONICALLY MENTALLY ILL AND OTHER VETERANS.

Section 115(d) of the Veterans' Benefits and Services Act of 1988 (Public Law 100–322; 102 Stat. 501; 38 U.S.C. 612 note) is amended by striking out "1989" and inserting in lieu thereof "1994".

SEC. 4. EXPANSION OF COMPENSATED WORK THERAPY PROGRAM.

(a) AUTHORIZED SOURCES FOR PROVISION OF THERAPEUTIC WORK.—Section 618 is amended—

(1) in subsection (a)—

(A) by striking out the first sentence and inserting in lieu thereof the following: "In providing rehabilitative services under this chapter to patients and members in Department health care facilities, the Secretary may use the services of such patients and members for the performance of Department functions if such use of services has therapeutic and rehabilitative benefits for such patients and members and is recommended by the Chief Medical Director."; and

(B) by striking out "Administrator" in the third sentence and inserting in lieu thereof "Secretary"; and

(2) in subsection (b)(1), by striking out "contractual arrangements with private industry or other sources outside the Veterans' Administration" and inserting in lieu thereof "a contract or other arrangement with any appropriate source (including any department or agency of the Federal Government)".

(b) PAYMENTS FOR SERVICES TO BE CREDITED TO THE SPECIAL THERAPEUTIC AND REHABILITATION ACTIVITIES FUND.—Subsection (c) of such section is amended—

(1) in paragraph (1), by striking out "carrying out the provisions of subsection (b)" in the first sentence and inserting in lieu thereof "furnishing rehabilitative services authorized in subsections (a) and (b)"; and

(2) in paragraph (2)—

(A) by striking out "contractual arrangements" and inserting in lieu thereof "contracts or other arrangements"; and

(B) by striking out "credited to the fund, and the Administrator" and inserting in lieu thereof "credited to the fund. The amount equal to the cost of the services performed by patients and members under subsection (a) of this section shall be paid out of funds available for the Department program, project, or activity benefiting from such services, and the amount so paid shall be credited to the fund. The Secretary".

(c) AVAILABILITY OF THE SPECIAL THERAPEUTIC AND REHABILITATION ACTIVITIES FUND FOR PAYMENT OF CERTAIN ADMINISTRATIVE EXPENSES.—Section 618(c)(1), as amended by subsection (b)(1), is further amended by inserting "(including defraying the costs of travel and related expenses necessary for the administration of services under such subsections or for the training of employees in the administration of such services)" before the period at the end of the first sentence.

SEC. 5. COMPENSATED WORK THERAPY COMMUNITIES.

(a) AUTHORITY TO ESTABLISH AND OPERATE THERAPEUTIC AND REHABILITATIVE ACTIVITIES TRANSITIONAL HOUSING.—Section 618 is amended by adding at the end the following new subsection:

"(g)(1) The Secretary may purchase, lease, or otherwise acquire residential housing and operate each residence so acquired as transitional housing solely for—

"(A) veterans who are furnishing services to the Department under subsection (a) of this section; and

"(B) veterans who are furnished therapeutic work pursuant to subsection (b) of this section.

"(2) Notwithstanding any other provision of law, the Secretary may use such procurement procedures for the purchase, lease, or other acquisition of residential housing for purposes of this subsection as the Secretary considers appropriate to expedite the opening and operation of transitional housing and to protect the interests of the United States.

"(3) A residence may be operated as transitional housing for veterans described in paragraph (1) of this subsection under the following conditions:

"(A) That homeless veterans have priority in filling residential vacancies in such housing.

"(B) That only veterans described in such paragraph and a house manager reside in such residence.

"(C) That each resident, other than the house manager, pay the Department rent for the period or periods of residence in such housing.

"(D) That, in the establishment and operation of such transitional housing in a community, the Secretary consult with appropriate representatives of such community and comply with zoning requirements, building permit requirements, and similar requirements applicable to other real property used for similar purposes in such community.

"(E) That the residence meet the State and community fire and safety requirements applicable to other real property used for similar purposes in the community in which the transitional housing is located.

"(4) The Secretary shall prescribe in regulations the qualifications for, and the fees for the services of, house managers for transitional housing operated under this subsection. The Secretary may provide for free room and subsistence for house managers in addition to or instead of payment of a fee for such services. The house managers shall not be considered employees of the United States for any purpose.

"(5) The Secretary may operate as transitional housing under this subsection—

"(A) any suitable residential property acquired by the Secretary as the result of a default on a loan made, guaranteed, or insured under chapter 37 of this title; and

"(B) any other suitable residential property purchased, leased, or otherwise acquired by the Secretary.

"(6)(A) In the case of the purchase of any property referred to in paragraph (5)(A) of this subsection, the Secretary shall transfer from the Special Therapeutic and Rehabilitation Activities Fund to the Loan Guaranty Revolving Fund the amount equal to the amount that the Secretary would charge for the sale of such property to a nonprofit organization or a State for use as a shelter for homeless veterans.

"(B) In the case of any residential property purchased by the Secretary of Veterans Affairs from the Department of Housing and Urban Development under this section, the amount charged by the Secretary of Housing and Urban Development for that property may not exceed the amount that the Secretary of Housing and Urban Development would charge for the sale of such property to a nonprofit organization or a State for use as a shelter for homeless persons.

"(7) Subject to the authority, direction, and control of the Secretary, the Chief Medical Director shall be responsible for the management, maintenance, and disposition of property acquired for the purpose of this subsection.

"(8) The Secretary shall prescribe—

"(A) a procedure for establishing reasonable rental rates for persons residing in transitional housing; and

"(B) appropriate limits on the period for which such persons may reside in transitional housing.

"(9) The Secretary may dispose of any property acquired for the purpose of carrying out this subsection when such property is no longer used for such purpose. The proceeds of disposition of such property shall be credited to the Special Therapeutic and Rehabilitation Activities Fund.

"(10) Except as provided in paragraph (3)(E) of this subsection, fire and safety requirements applicable to Federal Government buildings shall not be applicable to property operated as transitional housing under this subsection.".

(b) AVAILABILITY OF THE SPECIAL THERAPEUTIC AND REHABILITATION ACTIVITIES FUND FOR COMPENSATED WORK THERAPY COMMUNITIES.—Section 618(c), as amended by section 4 of this Act, is further amended—

(1) in paragraph (1), by inserting "and for the purpose of carrying out subsection (g) of this section" before the period at the end of the first sentence; and

(2) in paragraph (2)—

(A) by inserting "and all funds received by the Department as rent under subsection (g) of this section," in the first sentence after "paragraph (2) of such subsection,"; and

(B) by adding at the end the following: "The Secretary may also distribute out of the fund such amounts as may be necessary for the acquisition, management, maintenance, and disposition of real property for the purpose of carrying out subsection (g) of this section."

SEC. 6. NONPROFIT CORPORATIONS FOR VETERANS COMPENSATED WORK THERAPY PROGRAMS.

(a) AUTHORITY OF THE SECRETARY.—Chapter 73 is amended by adding at the end the following new subchapter:

"SUBCHAPTER VII—NONPROFIT CORPORATIONS FOR VETERANS COMPENSATED WORK THERAPY PROGRAMS

"§ 4171. Authority to establish; status

"(a) The Secretary may authorize the establishment of one or more nonprofit corporations to provide a flexible funding mechanism for the conduct of Department compensated work therapy programs for veterans (including homeless veterans) in such community or communities as the Secretary may designate. Except as otherwise required in this subchapter or under regulations prescribed by the Secretary, any such corporation, and its directors and employees, shall be required to comply only with those Federal laws, regulations, and executive orders and directives which apply generally to private nonprofit corporations.

"(b) Any corporation established under this subchapter shall be established solely to facilitate the conduct of compensated work therapy programs for veterans.

"(c) If, by the end of the three-year period beginning on the date of the establishment of a corporation under this subchapter, the corporation is not recognized as an entity the income of which is exempt from taxation under section

501(c)(3) of the Internal Revenue Code of 1986, the Secretary shall dissolve the corporation.

"§ 4172. Funds received by corporations

"(a) Except for sums used as provided in subsection (b) of this section, funds received by a corporation established under this subchapter for the conduct of compensated work therapy programs shall be transferred to the Special Therapeutic and Rehabilitation Activities Fund established under section 618(c) of this title and shall be administered by the Secretary for conducting such programs.

"(b)(1) Subject to paragraph (2) of this subsection, the corporation may use funds referred to in subsection (a) of this section to defray the administrative and fundraising expenses of the corporation.

"(2) Expenditures of the corporation shall be approved in advance in accordance with procedures prescribed by the Secretary.

"§ 4173. Board of directors; executive director

"(a) The Secretary shall provide for the appointment of a board of directors for each corporation established under this subchapter. The board shall include—

"(1) an officer or employee of the Department who—

"(A) is in a field office of the Department in or near the community or communities for which the corporation is established; and

"(B) is involved in the administration of section 618 of this title; and

"(2) representatives of the community or communities for which the corporation is established who are not officers or employees of the Federal Government.

"(b) Each such corporation shall have an executive director who shall be appointed by the board of directors with the concurrence of the Secretary. The executive director of a corporation shall be responsible for the operations of the corporation and shall have such specific duties and responsibilities as the board may prescribe.

"§ 4174. General powers

"A corporation established under this subchapter may—

"(1) accept gifts and grants from, and enter into contracts with, individuals and public and private entities solely for the purpose of facilitating the conduct of compensated work therapy programs;

"(2) employ personnel to carry out such purpose; and

"(3) fix the compensation of such personnel.

"§ 4175. Applicable State law

"Any corporation established under this subchapter shall be established in accordance with the nonprofit corporation laws of the State or States in which the community or communities for which the corporation is established are located and shall, to the extent not inconsistent with any Federal law, be subject to the laws of such State or States, as the case may be.

"§ 4176. Accountability and oversight

"(a)(1)(A) The records of a corporation established under this subchapter shall be available to the Secretary.

"(B) For the purposes of sections 4(a)(1) and 6(a)(1) of the Inspector General Act of 1978, the programs and operations of such a corporation shall be considered to be programs and operations of the Department with respect to which the Inspector General of the Department has responsibilities under such Act.

"(2) Such a corporation shall be considered an agency for the purposes of section 716 of title 31 (relating to availability of information and inspection of records by the Comptroller General).

"(b) Each such corporation shall submit to the Secretary an annual report providing a detailed statement of its operations, activities, and accomplishments during that year. The corporation shall obtain a report of independent auditors concerning the receipts and expenditures of funds by the corporation during that year and shall include that report in the corporation's report to the Secretary for that year.

"(c) Each member of the board of directors of a corporation established under this subchapter, each employee of such a corporation, and each employee of the Department who is involved in the functions of the corporation during any year—

"(1) shall be subject to Federal laws and regulations applicable to Federal employees with respect to conflicts of interest in the performance of official functions; and

"(2) shall submit to the Secretary an annual statement signed by the director or employee certifying that the director or employee is aware of, and has complied with, such laws and regulations in the same manner as is required of Federal employees.

"(d) The Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives an annual report on the number and location of corporations established and the amount of the contributions made to each such corporation.

"§ 4177. Report to Congress

"Not later than February 1, 1992, the Secretary shall submit to Congress a report on the experience through the end of fiscal year 1991 under this subchapter. The report shall include such recommendations as the Secretary considers appropriate.

"§ 4178. Expiration of authority

"No corporation may be established under this subchapter after September 30, 1992.

"§ 4179. Definition

"For the purposes of this section, the term 'compensated work therapy program' means any program of therapeutic and rehabilitative activities conducted under section 618 of this title.".

(b) CLERICAL AMENDMENT.—The table of sections at the beginning of such chapter is amended by adding at the end the following:

"SUBCHAPTER VII—NONPROFIT CORPORATIONS FOR VETERANS COMPENSATED WORK THERAPY PROGRAMS

"4171. Authority to establish; status.
"4172. Funds received by corporations.
"4173. Board of directors; executive director.
"4174. General powers.
"4175. Applicable State law.
"4176. Accountability and oversight.
"4177. Report to Congress.
"4178. Expiration of authority.
"4179. Definition.".

SEC. 7. USE OF FUNDS AVAILABLE FOR THE PILOT PROGRAM OF COMMUNITY-BASED CARE FOR HOMELESS CHRONICALLY MENTALLY ILL AND OTHER VETERANS.

(a) TRANSFER REQUIREMENT.—(1) The Secretary of Veterans Affairs shall transfer $1,625,000, and may transfer up to $5,000,000 out of appropriated funds referred to in paragraph (2), to the Special Therapeutic and Rehabilitation Activities Fund established in section 618(c)(1) of title 38, United States Code.

(2)(A) The funds referred to in paragraph (1) are funds that—

(i) are appropriated for the conduct of the pilot program established under section 115 of the Veterans' Benefits and Services Act of 1988 (Public Law 100–322; 102 Stat. 501; 38 U.S.C. 612 note); and

(ii) are contained in the first appropriation Act enacted on or after the date of the enactment of this Act that contains funds for the conduct of such pilot program.

(B) If the amount of the funds appropriated for such pilot program in the appropriation Act referred to in subparagraph (A) is less than the amount specified in paragraph (1), the Secretary shall transfer the amount so appropriated and funds appropriated for such pilot program in each subsequently enacted appropriation Act containing funds for such pilot program until the total amount transferred to the Special Therapeutic and Rehabilitation Activities Fund equals the amount specified in paragraph (1).

(b) TREATMENT OF TRANSFERRED FUNDS.—The amount transferred to the Special Therapeutic and Rehabilitation Activities Fund pursuant to subsection (a) shall be merged with sums in such Fund and shall be available for the same purposes and under the same conditions as other sums in such Fund.

SEC. 8. DEFINITIONS.

Section 101 is amended—

(1) by striking out paragraph (1) and inserting in lieu thereof the following:

"(1) The terms 'Administrator' and 'Secretary' mean the Secretary of Veterans Affairs (except when the context indicates otherwise)."; and

(2) by adding at the end the following:

"(33) The term 'Department' means the Department of Veterans' Affairs (except when the context indicates otherwise).".

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OPENING STATEMENT
SENATOR ALAN CRANSTON, CHAIRMAN
COMMITTEE ON VETERANS' AFFAIRS
HEARING ON
MENTAL HEALTH AND HEALTH-FACILITY SECURITY LEGISLATION

S. 13 (Sections 201, 202, 203, 204, and 221);
Amendment No. 124 to S. 13;
S. 86, S. 192, S. 405, S. 846
June 14, 1989

Good morning and welcome to each of you. Today's hearing concerns legislation relating to Department of Veterans Affairs mental health programs. Although VA plays a vital role in providing psychiatric care to veterans -- a large percentage of whom are service-connected -- it is an area that has too often been neglected. It is my intent -- as demonstrated by the Committee's continued interest in this area -- that VA end that neglect and bring to bear the resources necessary to provide quality psychiatric care. Specifically, we will be receiving written and certain oral testimony on: Sections 201 through 204 of S. 13, the proposed "Veterans' Benefits and Health Care Act of 1989", a bill I introduced on January 25, 1989, that is cosponsored by Committee members Matsunaga, DeConcini, Rockefeller, Mitchell, and Graham and Senators Burdick and Kerry. These provisions address various issues relating to post-traumatic stress disorder (PTSD) treatment and research.

Amendment No. 124 to S. 13, which I submitted on June 1, 1989, along with the first 5 of these same 7 Senators, would require VA to conduct a 5-year pilot program to encourage and establish non-profit corporations with which VA would contract to run compensated work therapy (CWT) programs in conjunction with therapeutic residences. (TRs) Section 221 of S. 13, which would (a) assign to an Assistant Secretary of Veterans Affairs responsibility for the functional and technical supervision of the performance of security and law enforcement functions in VA; and (b) require the Secretary of Veterans Affairs, within 90 days after the enactment of this legislation, to submit a report containing a plan for upgrading VA police officer training, recruitment, and salaries and assessments of the need for a policy to allow VA police officers serving at medical centers in high crime areas to carry weapons for self- protection and of the feasibility of reducing police services in centers with no significant security problems in order to expand such services in centers with greater problems.

However, in order to gain the testimony on these matters of VA's Deputy Secretary, who will be testifying at our hearing next Thursday, we are not going to take any oral testimony today on the security legislation or issues pertaining to them. Instead, we will ask our questions of the Deputy Secretary next week and will be asking VA to provide us with a thorough description of its security program by early next week.

S. 86, which I introduced along with Senators Murkowski, Matsunaga, DeConcini, Rockefeller, and Graham, and which would improve VA mental-health care through the establishment of up to five Mental Illness Research, Education, and Clinical Centers (MIRECCs).

S. 192, introduced by Senator Matsunaga, Inouye, and me, which would require VA to conduct a study of postwar psychological problems among certain minority veteran populations.

S. 405, which I introduced along with Senators DeConcini and Matsunaga, and which would provide for a three-year extension, through FY 1992, of VA's successful program of community-based residential treatment for homeless chronically mentally ill (HCMI) veterans and make the program no longer of a pilot nature.

S. 846, introduced by Senator Murkowski, which would (a) extend the HCMI pilot program for five years; (b) authorize CWT contracts with federal agencies, (c) provide for non-profit corporations to act as funnels for donations to VA, and (d) provide for direct VA activity to establish and run CWT and TRs.

SECTIONS 201 THROUGH 204 OF S. 13: PTSD

BACKGROUND

Last year, I introduced provisions, similar to sections 201 through 204 of S. 13, relating to PTSD, which were passed by the Senate on October 18, 1988, in sections 601-603 of S. 2011 but, unfortunately, were not agreed to by the House of Representatives and were not enacted into law. Postwar psychological problems have long been known to occur among war veterans. Such problems have been known as shell shock, war neurosis, and combat fatigue. In 1980, the American Psychiatric Association officially adopted the term PTSD to denote a psychological disorder that stems from exposure to an extraordinarily traumatic event. PTSD varies in intensity - from dampening an individual's ability to participate to the fullest degree in life to total incapacitation when suicide appears to be the only hope of escape.

The recently released Research Triangle Institute (RTI) study of the post-war psychological problems of Vietnam veterans, mandated by section 102 of Public Law 98-160, indicates an alarming prevalence of PTSD among Vietnam theater veterans. According to the RTI data, 15.2 percent of the male Vietnam theater veterans (479,000) and 8.5 percent of the female theater veterans (610) are currently suffering from full-blown cases of PTSD. Another 11.1 percent of males and 7.8 percent of female theater veterans, or a total of 350,000 theater veterans, suffer from PTSD symptoms which adversely affect their lives but whose symptoms are not of the intensity or breadth required for a diagnosis of full-blown PTSD.

These data indicate -- and I believe this is a very alarming statistic -- that, almost 20 years after the vast majority of our troops left Vietnam, 829,000 of the 3.14 million Vietnam veterans are currently suffering from some degree of PTSD. Even more significantly, the RTI data indicate that only 10 percent of those veterans with full-blown cases of P.T.S.D. have seen a mental health professional on at least one occasion, and of those, it remains unknown how many actually pursued any real course of treatment.

Currently, VA has only 16 specialized inpatient PTSD units (SIPUs), with four new SIPUs to be added in FY 1990. Currently, all of the SIPUs have a waiting list for admission to the treatment program, ranging from several weeks at the Menlo Park VAMC to one year at the American Lake VAMC (Washington). In addition, the majority of SIPUs have waiting list for admission for screening programs, in which veterans are admitted for a few days, assessed, discharged, and, if deemed appropriate then put on the waiting list for admission. These screening waiting lists range from a week at the Coatesville VAMC to 32 weeks at American Lake. This arrangement means that a veteran with PTSD in the American Lake region must generally wait a total of 20 months -- almost two years -- to get the needed treatment. Given that many clinicians see the SIPUs as providing intensive care to patients in acute need of treatment, these waiting lists present a tremendous inadequacy in the system's ability to meet its top-priority responsibility -- the provision of quality care in a timely way to veterans suffering from service-related disabilities.

In addition to the SIPUs, I understand that VA will shortly be designating 23 PTSD Clinical Teams (PCTs) (teams of four personnel -- two funded by Central Office and two from the existing budget at the medical centers -- including one psychiatrist, who are specially trained in diagnosing PTSD) to specialize in PTSD treatment at 23 of its 172 medical centers. These PCTs will be taking the place of the former VA treatment teams which previously were at 15 VAMCs. The Special Committee on PTSD reported in its 4th annual report that several teams had been "cannibalized" by the local VAMCs and existed only on paper, while certain others were simply ineffective at their mission. Using the additional $5 million I was successful in getting appropriated for PTSD treatment in FY 1989 (Public Law 100-404), VA decided to create 8 to 10 new treatment teams. To address the concerns about the effectiveness of those teams already in the field, VA rescinded their designation and required all interested VAMCs to submit proposals. The ultimate culmination of this very lengthy process will be the designation of 23 new PCTs. It is regrettable that these efforts will become operational so late in this fiscal year.

In another effort to improve the quality of care of PTSD patients, VA is also planning on using a portion of the $5 million to create four PTSD Substance Use Disorder (PSU) programs, one of which has been designated at the Menlo Park facility, which -- typically for it -- already has been conducting a pilot program of this nature over the last year. Often, PTSD sufferers also abuse drugs and alcohol in their attempts to dull their psychological pain by "self-medicating" themselves. Most SIPUs require veterans to be clean of drugs or alcohol prior to receiving treatment for PTSD, but PSUs, recognizing that it can be unreasonable to demand that a veteran overcome his or her substance or alcohol abuse problem prior to receiving treatment for PTSD -- since often the two problems are inseparable -- will offer treatment for both problems together.

These modest treatment efforts are laudable, but they are totally inadequate in the face of the enormous unmet needs of veterans with combat-related PTSD. Moreover, these VA actions come only after Congress took the initiative in adding the $5 million -- over 40 percent of which VA Central Office decided to assign to activities other than direct P.T.S.D. treatment programs. I believe VA has been generally slow and unresponsive in carrying out its responsibilities as to PTSD, and I intend to continue to press the Department in this regard.

It is all well and good for the Department to devise innovative programs to address chronic mental illness and to stimulate Congressional interest in innovative therapies in conjunction with CWT -- which we will address this morning. But VA's major mission is to deal with service-related conditions, and its medical leadership has never displayed the sensitivity to this mission that I believe is called for -- especially in the case of the PTSD treatment needs so dramatically illustrated by the RTI report. These shocking and highly disturbing RTI data have been available to VA for almost a year now. Yet the VA still has not made available to the Committee, despite persistent requests for it, a plan to deal with the tremendous unmet need for treatment on the part of almost a half million Vietnam veterans with full-blown PTSD right now! What we hear over and over from VA's medical leaders is let us study the problem more.

Well, the time for study is long past and the time for action on the PTSD front is now!

Sections 201 through 204 of S. 13 are designed to bring about the type of responsiveness to PTSD that many of us feel has been sorely lacking in VA.

Section 201 -- Priority Care for Veterans with Combat-Related PTSD

Section 201 would require VA to furnish needed inpatient and outpatient mental health services to a veteran whom a mental health professional designated by the VA's Chief Medical Director has diagnosed as suffering from combat-related PTSD. This treatment would be furnished on the same basis as if the veteran had been adjudicated as being service-connected.

In eliminating the need for a pre-treatment adjudication of service-connection by the Department of Veterans' Benefits, this provision also acknowledges the particular difficulties of veterans afflicted with PTSD. Among the symptoms of PTSD are persistent avoidance of situations associated with the trauma, difficulty concentrating, irritability or outbursts of anger, and intense psychological distress at exposure to events that symbolize the traumatic event. It is a difficult and stressful situation for veterans with PTSD to seek help of any kind, and the VA claims-adjudication process is one that many are unwilling or unable to undergo. For veterans suffering from PTSD, the pre-treatment adjudication process may serve as an administrative barrier to desperately needed mental health care, and section 201 seeks to remove this barrier.

Section 201 would apply not only to Vietnam veterans, but to all veterans of service in a combat theater of operations. Testimony at the Committee's July 14, 1988, hearing last year indicated that substantial numbers of veterans from the Korean war and World War II also suffer from PTSD, and I believe that there is no reason to limit this provision to Vietnam veterans. Thus, veterans of service in theaters of operations during prior periods of war -- for example, the European or Pacific theaters during WW II -- and veterans of service in areas where United States personnel were subjected to danger from armed conflict comparable to that of battle with an enemy during a period of war -- such as in Beirut or Grenada -- would all be eligible for priority care under this provision once they are authoritatively diagnosed as suffering from combat-related PTSD.

This provision would likely result in a reallocation of VA resources as more treatment is furnished to veterans with PTSD. I believe such a reallocation for the benefit of PTSD sufferers is very much in order when the VA's own study data demonstrate so clearly that so many veterans are not receiving care for this psychological disorder that has grown out of their combat service.

Section 202 -- VA's Special Committee on PTSD

Section 202 concerns the future role of the VA's Special Committee on PTSD. This provision would require it to submit three additional reports to the Secretary and concurrently to the two Veterans' Affairs Committees. The first report, due by June 1, 1989, would be required to set forth the Special Committee's evaluation of the results of the RTI study that I mentioned earlier. The Special Committee would be required to provide its assessment of the VA's capability to meet the need for diagnosis and treatment of veterans with PTSD, an evaluation of the Secretary of Veterans Affairs' report on the study, and recommendations for any further or follow-up research on the matters addressed in the study. The Secretary would be required to submit to the Veterans' Affairs Committees, within 30 days after receiving the report, any comments concerning the report that the Secretary considers appropriate. The second and third reports, due by February 1 of 1991 and 1992, respectively, would be required to provide information updating prior reviews of the overall efforts of the VA to meet the needs of veterans with PTSD. Not later than 60 days after receiving each of the reports, the Secretary would be required to submit to the Committees any comments concerning the report that the Secretary considers appropriate.

The Special Committee has provided extremely useful information to this Committee, to the House Veterans' Affairs Committee, and to the Secretary regarding PTSD. Because of the important role the Special Committee has played in identifying problems and solutions, I believe that the additional reports I have described would be extremely useful to the Congress as we continue our efforts to convince VA's medical hierarchy and political leadership that much more needs to be done to help meet the needs of veterans with PTSD.

Section 203 and S. 192 -- Study of PTSD Among Certain Minority Veterans

Section 203 of S. 13 and S. 192 would require VA to conduct a scientifically valid study -- either in-house or by contract -- on the incidence of PTSD and other postwar psychological readjustment problems among various racial/ethnic groups that were not included in the RTI study. VA would be required to submit a report on the findings of the study to the two Veterans' Affairs Committees by October 1, 1991. Although the RTI study oversampled the racial/ethnic groups of blacks and Hispanics, and also oversampled women veterans in order to develop estimates of the prevalence of PTSD and other readjustment problems among these groups, it did not oversample Vietnam veterans who are Asian-Americans, American Indians, Native Hawaiians, and other Native American Pacific Islanders, and Alaskan Natives. The study required by section 203 would sample these groups to determine the incidence of such problems among them.

Based on the data supplied by the RTI study, it appears that the prevalence of PTSD among racial/ethnic groups is much higher than among whites. For example, the findings for racial/ethnic subgroups of male Vietnam theater veterans indicate that the prevalence of PTSD for whites/others is about 14 percent, while for blacks the prevalence is 19 percent and for Hispanics it is as high as 27 percent. Several witnesses at our July 14, 1988, hearing also described various ethnic/racial racial groups, including blacks and Asian-Americans, as being reluctant to seek treatment. This reluctance may lead to an incomplete understanding of the scope of this disorder in such populations.

Section 204 -- Funding for Post-Traumatic Stress Disorder Programs

Section 204 would require VA to identify the type and amount of resources it spends on PTSD-related activities. This section would require VA, when submitting its annual budget documents to the Congress, to identify the amounts to to be obligated in the upcoming fiscal year for: First, payment of compensation to veterans for disabilities resulting from service-connected PTSD; second, the treatment of veterans for PTSD related to their active-duty service, including specific designation of funds for inpatient care -- specialized programs, general programs, and treatment teams -- outpatient care, Vet Centers, and contact care; third, PTSD education, training, and research (at the National Center for PTSD, at any Mental Illness Research, Education, and Clinical Centers (MIRECCs) that may be established under S. 86, and generally); and, fourth, for the operation of the National Center for PTSD.

I believe that requiring VA to focus in this manner on its allocation of resources to PTSD-related activities would help bring about more adequate provision for meeting the needs of veterans who, due to the combat-related nature of their illness, are so deserving of help on a priority basis and who so greatly need that help.

AMENDMENT NO. 124 TO S. 13: COMPENSATED WORK THERAPY AND THERAPEUTIC RESIDENCES

Amendment No. 124 to section 212 of S. 13 concerns the compensated work therapy (CWT) programs operated by the VA. CWT programs provide, at a low cost to the Government, numerous therapeutic benefits to VA patients, especially those who are chronically mentally ill. These programs, authorized under section 618(b) of title 38, and funded by a revolving fund called the Special Therapeutic and Rehabilitation Activities Fund (STRAF), provide a clinical procedure for evaluating and developing the veteran-patient's vocational interests, aptitudes, and skills, as well as assessing the patient's physical and mental capacities for work in actual work situations. These programs encourage the development of good work habits by emphasizing attendance, reliability, punctuality, productivity, craftsmanship, and personal responsibility. In essence, individuals working in compensated work therapy gain a sense of being productive while developing important work skills.

CWT programs involve the use of work subcontracted and paid for by industries. Wages are generally paid on a piece-work basis and are provided and generated through the work contracts. The jobs vary greatly, from simple packaging to fabrications and assembly operation using complex machinery. Activities take place in VA medical centers, in the community, or on industrial sites. In fiscal year 1988, CWT programs provided work for 5,632 veterans in 45 programs through contracts with businesses that paid out over $3 million. Patients worked 836,438 hours and were paid a total of $1,879,602, Approximately 40 percent of the program participants were outpatients, and almost all (approximately 90 percent) were either psychiatric or substance-abuse patients.

As FY 1988 drew to a close, it became apparent that further expansion of the CWT programs was being hampered by restrictions on contracting sources and a lack of funding for training, travel, and other necessary management operations. Subsections (a) and (b) of section 212 as proposed to be amended address these obstacles to growth of the CWT programs. At that time, I also had underway work on legislation to test ways of expanding the CWT program through projects operated in conjunction with therapeutic residences (TRs). Subsection (c) provides for such a pilot program.

Subsection (a) would expand VA's contracting authority with respect to CWT programs. Under current law -- section 618(b)(1) of title 38 -- CWT programs are limited to contracting solely with "private industry or other sources outside [VA]." VA's General Counsel has indicated that this language restricts contracting not only with the VA but with other governmental agencies as well. With contracts already difficult to find, especially in rural areas, such a restriction can stultify further growth in the program. In order to remove these restrictions and aid the growth of CWT programs, subsection (a) would authorize CWT programs to contract with any private or governmental entities, including the VA. The kinds of work that CWT participants might perform for governmental agencies would include landscaping, housekeeping, and machine repair.

Subsection (b) would authorize the use of STRAF money for training and related management functions, including travel, necessary for the operation of CWT programs. Due to the VA General Counsel's interpretation that the language in section 618(c)(1) prohibits expenditures from STRAF for travel to local sites for training purposes, little or no money is currently available for the purposes of conducting on-site training programs for local personnel. The programs suffer from a lack of training resources, and the growth of the program to new sites are hampered by a dearth of properly trained personnel. Subsection (b) would remove the restriction on the use of STRAF money, thus better using the STRAF and encouraging growth of the program.

Subsection (c) would establish a five-year pilot program to further expand and enhance VA CWT programs. This pilot program would provide for testing, at up to 25 sites, of an innovative approach to providing veteran-patients -- primarily those recovering from mental disabilities or drug or alcohol conditions -- with the services to help them make the transition form inpatient care to independent living in the community.

Under the pilot program, VA would help to create non-profit corporations with which it would enter into contracts to conduct CWT programs and to which it could make loans to facilitate the corporations in setting up therapeutic residences (TRs) providing relatively independent, transitional group-living arrangements. In order to be eligible to receive a CWT contract under this program, the corporation would have to operate a TR. These CWT/TR programs would provide work therapy during the day and a supervised living experience at night. The specific provisions of the pilot program may be summarized as follows:

First, VA would be required, in not more than 25 sites at VA medical centers which already have CWT programs, to promote and participate in the establishment of non-profit corporations. Such a corporation would enter into a contract with the VA to run CWT programs for as long as it actually runs a TR.

Second, VA would be authorized to make an interest-free loan -- repayable within five years -- to the non-profit corporation in the amount of either 25 percent of the purchase price for the building to be used as a TR or the total of the first year's rent it would pay to lease a structure for that purpose. If the non-profit were later to sell the property used as a TR, the proceeds of the sale would be required to be used to repay the unpaid balance of the loan and to pay VA 50 percent of any profit realized from the sale.

Third, VA would be authorized to make advance payments, under the non-profit corporation's contract with VA to run a CWT program, from the STRAF by making those funds available in a special escrow account set up in the STRAF. Funds would be disbursed from the escrow account to the non-profit upon its demonstrating to VA's satisfaction that at least 25 percent of the annual operating expenses for running the TR (over and above the expenses anticipated to be paid from VA patients' rental payments) would be paid from non-VA sources (either in cash or in-kind services).

Fourth, VA would be authorized to provide as part of VA's payment to the non-profit for the running of a CWT program in conjunction with a TR, in-kind services (including technical and clinical expertise, building renovation supervision, and minor maintenance and repairs to the residence) to the non-profit corporation. For purposes of VA's Resources Allocation Methodology (RAM) (a methodology VA uses in allocating funding to its health-care facilities), such services would be considered as "pass through" expenses and accordingly, would not be subject to adjustment by the RAM.

Fifth, the non-profit corporation would be (a) authorized to use the funds advanced to it by VA under the CWT contract to assist the corporation to acquire and operate a TR, and (b) required, when it ceases to operate the TR, to return to the STRAF out of the proceeds from the sale of the property any amount it owes to VA under the CWT contract with the VA.

Sixth, VA would be authorized to transfer to the STRAF from the General Post Fund at the medical center involved the funds necessary for any loan or advance payment to be made to the non-profit corporation in connection with the pilot program at that center.

Seventh, the Secretary would be required, in administering chapter 37 of title 38, the VA home-loan guaranty program, to transfer not less than ten properties acquired by VA under that chapter to the Veterans Health Services and Research Administration (VHS&RA) for VHS&RA to lease the properties to non-profit corporations which have CWT contracts and agree to use the properties as TRs for terms of one to three years, with renewal options. The non-profit corporation would be required (a) to pay 60 percent of the rent collected from patients to the medical center for subsequent transfer into VA's Loan Guaranty Revolving Fund, and (b) upon termination of the lease, to return the property to the Secretary for disposition in accordance with loan guaranty program procedures.

Eighth, any existing non-profit corporation carrying out a CWT program would be grandfathered in its CWT operations without regard to the provisions in the bill.

Ninth, the structure of the CWT/TR non-profit corporations would be similar to -- although revised in certain aspects from -- that of the research non-profit corporations, which are currently authorized in subchapter VI of chapter 73 of title 38, in terms of general powers, the structure of their boards of directors (but VA employees must be a minority of board members), the applicability of State law, accountability, oversight, and authority to accept gifts or grants.

I envision the program working as follows: Once VA employees perceive, or are able to develop, an interest in the community in providing transitional housing and appropriate therapeutic work opportunities for chronically mentally-ill veteran patients or veteran patients with substance-abuse problems, they would join with the interested individuals from the community -- some or most of whom very likely would be members of veterans service organizations -- to form a non-profit corporation. I note with great interest the actions of the American Legion in Pittsburgh and the keen interest expressed by the Disabled American Veterans in its testimony in becoming actively involved in setting up such non-profit corporations. The goal of such a non-profit corporation would be to run a CWT program for veterans in conjunction with establishing and running a TR. The responsibility for the project would be with the non-profit corporation; the VA would be supportive in tangible and promotional ways, as I have outlined.

This program would be a unique, innovative, and cost-effective improvement to VA's CWT programs. Without broadening VA's health-care mission into the direct operation of therapeutic residences in local communities at a time of extreme budget pressures for the VA health-care program, this legislation would provide a mechanism for mobilizing and utilizing community resources to make available the transitional support provided by therapeutic residences to those veterans who most need it -- those with mental disabilities or substance abuse problems.

S. 86, the proposed "MENTAL ILLNESS RESEARCH, EDUCATION, AND CLINICAL CENTERS"

This bill, which I introduced along with Senators Murkowski, Matsunaga, DeConcini, Rockefeller, and Graham, would require VA to establish up to five mental illness research, education, and clinical centers [MIRECCs]. These centers would improve and expand the capability of VA health-care facilities to respond with the most effective and appropriate services possible to the needs of veterans suffering from mental illness, especially from those conditions that are service related. MIRECCs would also advance scientific knowledge regarding how to evaluate and treat mental illness by coordinating research, the training of health personnel, and the development of improved models of clinical services -- including treatment for PTSD -- for eligible veterans suffering from mental illness. This bill is nearly identical to S. 2436, which was passed by the Senate in a slightly modified form as section 604 of S. 2011 on October 18, 1988, but was not accepted by the House and was not enacted into law.

The need for improvement in the mental-health-care capability of VA medical facilities is great. The Special Purpose Committee to Evaluate the Mental Health and Behavioral Science Program of the VA -- also known as the Kety Committee -- released a report on October 20, 1985, in which it found that research on mental illness and training for psychiatrists and other mental health specialists at VA facilities was totally inadequate. The report stated that less than 10 percent of VA research resources are directed toward mental illness; in contrast, about 40 percent of all VA bed-days are provided to veterans who suffer from mental disorders, including PTSD, Alzheimer's disease, alcoholism and substance abuse, and depression.

In 1983, one-third of all VA patients had a primary psychiatric diagnosis, and a great number of the rest also had significant psychiatric disorders, such as alcoholism or depression. The Kety report concluded that educational funds, training stipends, research space, and staff positions for psychiatry were disproportionately low in the VA, resulting in high caseloads and diminished opportunities for research. Although 42 percent of all applicants for VA career development awards are funded, only 26 percent of the psychiatrists who apply are funded. The report concluded that many VA mental-illness researchers are discouraged from applying for funding. Additionally, the VA is increasingly unable to attract young, research-oriented psychiatrists and mental health professionals and is, therefore, less able to offer the same opportunities for innovative treatments to veterans with mental illness as do other psychiatric facilities.

The Kety Committee recommended, among other things, that centers of excellence be established as a cost-effective and rapid way to develop psychiatric research in the VA system. The report noted that the centers would produce new knowledge, provide researchers, and eventually would generate well-trained clinical investigators who could then initiate research projects at other VA hospitals. S. 86 would authorize the creation of five MIRECCs in order to implement the recommendation of the Kety report. These MIRECCs would be modeled after the VA's very successful geriatric research, education, and clinical centers (GRECCs) program that has been carried out for the last decade under section 4101(f) of title 38.

Each MIRECC would be required to maintain arrangements with an accredited medical school, graduate school of psychology, nursing, social work, or other allied health personnel school under which residents or students would regularly rotate through the VA medical center so as to provide hands-on training in the diagnosis and treatment of mental illness. MIRECCs would also be required to maintain research programs that would attract scientists and physicians capable of ingenuity and creativity in mental health research efforts. MIRECC researchers would be given priority for funding for VA research grants. In addition, the bill would require the Secretary to report to the Congress periodically on the research, educational, and new clinical-care activities at each MIRECC and on efforts to disseminate the information throughout the VA system.

Finally, this bill would require at least one MIRECC to be designated by the Secretary by July 1, 1990, and would authorize the appropriation of $3.125 million in fiscal year 1990 and $6.25 million for each of the next three years for the MIRECC program. As is the case with the GRECCs, I would expect that funding for the MIRECCs would not be subject to the resource allocation methodology.

S. 405 -- THE PROPOSED "COMMUNITY-BASED RESIDENTIAL CARE FOR

HOMELESS CHRONICALLY MENTALLY ILL VETERANS" ACT

S. 405, which I introduced along with Senators DeConcini and Matsunaga, would provide for a three-year extension of the VA's highly successful program of community-based residential treatment for homeless chronically mentally ill veterans (HCMI program), codify the program in title 38, and remove its designation as a pilot program. The bill would also extend for three years the authority to include in the program veterans who have service-connected chronic mental illness disabilities and chronically mentally ill veterans who are receiving VA hospital or nursing home care. It would also expand this discretionary authority to include chronically mentally ill veterans with service-connected disabilities rated at 50 percent or more, who were included in the original program in 1987 before it was narrowed at the insistence of the House Committee in conference on S. 9/H.R. 2616 last year.

The HCMI Program was first authorized in 1987 under section 2 of Public Law 100-6 as a contract authority. In 1988, under section 115 of Public Law 100-322, the Veterans' Benefits and Services Act of 1988, the contract authority was replaced by a requirement for VA to conduct in fiscal years 1988 and 1989 a pilot program for HCMI veterans and an authority for the agency to include in the program only those veterans with service-connected chronic mental illness disabilities and chronically mentally ill VA hospital and nursing home patients. Through the HCMI Program, in combination with the special homeless veterans domiciliary-bed program, which was fully authorized in Public Law 100-322, the VA has provided shelter and medical and psychiatric treatment for over 11,000 homeless veterans who are in desperate need of such help.

Section 801 of the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, authorized $15 million to be appropriated (in addition to any funds appropriated pursuant to any other authorization) for each of fiscal years 1989 and 1990 for the furnishing of care and services to homeless veterans under the current program authority in section 115 of Public Law 100-322 . Our bill would replace the reference in section 801 of the 1988 McKinney law with a reference to the proposed new section 620C of title 38. It is our expectation that any future extension of the McKinney authorities would include appropriate authorizations of appropriations for the furnishing of services to homeless veterans under this section.

Finally, this bill would require the Secretary to submit, not later than February 1, 1992, to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the experience of the Department under this bill and the recommendation of the Secretary -- together with the reasons for such recommendation -- as to whether the program should be continued.

The HCMI Program is a community-based program for homeless chronically mentally ill veterans that combines aggressive outreach with health services, intensive case management, and time-limited care in non-VA residential treatment centers. The results from the program have been encouraging. The second annual report detailing the progress of the HCMI Program was submitted to the Committee on Veterans' Affairs on January 17, 1989. It reveals that, in the first 11 months of the program, operations in 43 VA Medical Centers in 26 states -- including five sites in California -- and the District of Columbia were able to assess 10,524 veterans and place 2,125 of them in residential treatment facilities.

Preliminary data about the outcome of treatment in community-based residential treatment are available for 1,356 episodes of treatment and for 638 veterans involved in the follow-up evaluation. These preliminary data show that only about one in four enrolled veterans successfully completed the program. Specifically, of those discharged from HMCI residential treatment programs, 25.6 percent were judged to have completed the program successfully, 32.7 percent left against medical advice, and 20.5 percent were discharged for violation of program regulations -- often for using drugs or drinking. In 10.6 percent of the cases, the veterans left to obtain more intensive medical or psychological treatment elsewhere.

Not surprisingly, because the need for ongoing care is the rule rather than the exception in the care of chronically mentally ill persons, the clinicians determined that, at the time of discharge, about half of the veterans had shown improvement but were in need of additional treatment, while only 1 to 8 percent had improved to the point of needing no further treatment.

Given the difficult nature of contacting these veterans -- in soup kitchens and shelters, on the streets, in deserted buildings, and under bridges -- and of building trust between the veteran and the outreach worker, which is so very necessary to make an assessment and provide for physical and mental examinations, the numbers of veterans assessed and placed demonstrate a real success on the part of the outreach workers, and, consequently, a relative success on the part of the program itself. Nevertheless, a 25-percent-success rate does suggest questions about cost-effectiveness in this time of such scarce and strained resources, especially when VA mental health leaders are agitating for legislation to promote other experimental, promising therapies while VA's basic efforts to treat PTSD as well its overall low priority for mental health efforts are so disappointing. Hence, I will be asking the General Accounting Office to conduct a review of the HMCI program.

This bill would accomplish several important objectives. By removing the pilot program designation, it would be recognizing the relative, preliminary success of the program and especially the ongoing needs of those veterans who need assistance. Additionally, in practical terms, it would allow the VA to offer term or career positions, complete with employee fringe benefits, to those individuals working in the program. I understand that there is a high burnout rate among the outreach workers and others working with homeless veterans -- under often very trying conditions -- and that it is difficult to find replacements, due in part to the lack of job security and lack of benefits. I believe that the combination of the recognition of a job well-done and the opportunity for employment with health-insurance and other benefits should have a positive effect on the recruitment and retention of the professionals and other personnel involved in this program. This approach seems preferrable to merely extending the program as a pilot program, as proposed in S. 846.

S. 846 -- the proposed "Veterans Compensated Work Therapy Program Improvements Act of 1989"

S. 846, introduced by the distinguished Ranking Minority Member, Senator Murkowski, proposes a different approach to several programs addressed in legislation I have introduced. With regard to the HCMI program, S. 846 would keep the program as a pilot program, but reauthorize it for 5 more years.

With regard to the VA's CWT programs, Senator Murkowski and I agree on two basic things: First, that expansion of VA's contracting authority to allow contracts with the federal government is appropriate; and, second, that transitional housing for veterans engaged in CWT programs is desirable. However, S. 846 would also authorize VA to establish transitional housing by direct purchase, lease, or rental of residential property in which the VA would directly operate TRs for veterans participating in the CWT Program. Under the express provisions of S. 846, non-profit corporations would apparently serve only as indirect funding mechanisms -- shells -- for the CWT programs. The funding for this new VA program would come from raiding the funds authorized and appropriated for the HCMI program. S. 846 would require the VA to transfer $1.625 million, and authorize the transfer of up to $5 million more, from the HCMI program to the STRAF, to enable VA to expand into this new CWT/TR area of care.

Given the fiscal crisis throughout the VA health-care system, I do not see how we can be pursuing this type of expansion, especially at a cost to the thousands of homeless veterans who so desperately need the type of help that the HCMI program is designed to provide. At a time when the basic VA system is struggling merely to continue and is facing enormous fiscal and personnel recruitment and retention pressures, I believe it would be unwise to direct any significant new or existing appropriations into a new program that is not a part of direct health care and is not directed toward solving VHS&RA's urgent recruitment and retention problems.

I also favor the non-profit approach rather than direct Federal operation because it involves the local community in the care of local veterans through a community-based mode of care. Additionally, this kind of program is particularly appropriate for a private-sector entity -- especially with the encouragement from VA that is provided for in the legislation I have proposed -- which can operate with far more freedom and flexibility than a government department.

Another reason for utilizing the non-profit model over a direct VA-run TR is the issue of federal liability for a TR located off VA grounds which does not have direct VA supervision on a 24-hour basis. This could become a serious issue since part of the clinical aspect of the TR may require giving patients sufficient independence to learn and grow and emerge from the direct supervision of others, I believe very strongly that this emergence can happen more readily apart from a government-run entity.

SECTION 221 OF S. 13 -- HEALTH CARE FACILITY SECURITY

Section 221 of S. 13 addresses -- in ways outlined earlier in this statement -- a number of issues associated with VHS&RA's security police force. Although the section addresses certain policies and practices regarding the VA police force which I believe need to be corrected, I want to be very clear about the fact that there are many, many dedicated police officers who work -- often at unfairly low wages -- in high-crime, often dangerous areas every day to make the VA medical system safe for patients and staff. I applaud their efforts on behalf of our Nation's veterans.

The hiring practices for VA police officers by VA medical center officials, the training of VA police officers, and the extent to which VA police officers can protect themselves on the job have come under intense scrutiny and criticism in the last year following the killing of 3 police officers on duty by armed perpetrators over the last several years. In a September 30, 1988, report entitled "Audit of Hiring Practices for VA Police Officers", VA's Inspector General found that 57 percent of VA police officers surveyed were either unqualified, unsuited, or both, for their current positions, including 21 then current police officers who did not disclose prior criminal convictions on their applications for employment. In FY 1988, $7.7 million in damages was incurred at VA medical centers in numerous incidents of vandalism, general disturbances, forced entries, and robberies.

VA's prepared testimony for this hearing constitutes a most cursory and superficial statement on these issues. This inattention provides absolutely no reason to be encouraged about VHS&RA's efforts to resolve the problems plaguing VA security efforts.

I would have thought that VHS&RA would have taken the opportunity to inform the Committee in some detail about the size, scope, composition, and activities of its police force. But the prepared statement provides no such data. I would have thought also that VHS&RA would have taken the opportunity to tell us about the specific corrective measures it has taken in VA police hiring practices and training programs since the IG report was issued. But the statement is equally lacking on that account as well. I truly had hoped for a more positive written statement on this issue to demonstrate that VHS&RA is truly serious about improving a situation that I believe, based on independent staff investigations, is badly in need of strong centralized direction, more resources, and a clear understanding of the problems that VA police officers face daily in staffing magnetometers without themselves having any means of disarming someone found to be carrying a weapon and without a policy that requires them to wear protective vests which VA should be providing to them.

Because VHS&RA's testimony was so uninformative on the security issue, I am submitting today requests for a great deal of information to be provided by next Monday. Also, since the issue of the organizational location of health-care-facility security police in VA's organizational structure is one that involves VA top management, and since I believe that the Secretary and Deputy Secretary need to monitor closely the extent to which VHS&RA is moving effectively, and is capable of doing so and inclined to do so, to resolve its problems in this area, we are delaying taking oral testimony on this section in S. 13 until the June 22, 1989, hearing at which Deputy Secretary Tony Principi is scheduled to testify.

Recently-Released VA Mortality Study

Yesterday, VA released its long-awaited mortality study entitled "Review of Mortality in VA Medical Centers", and I want to make a few comments on that study at this time. Because so few studies have been published in the area of mortality, and no study is available to directly compare with this VA study, the VA report is difficult to interpret. I suspect, however, there is no cause for major concern on the part of veterans and their families relying on the VA general medical and surgical hospitals.

According to this study, "likely" quality-of-care problems exist in 5.1 percent of a sample of deaths within all Department of Veterans Affairs (VA) medical centers during 1986 -- 3.7 percent have likely problems if only medical and surgical facilities are reviewed separately and a staggering 10.4 percent have a likely problem if only acute medical and surgical wards of primarily psychiatric VA medical centers are studied.

Although I am, of course, always concerned about the overall quality of care furnished in VA hospitals, I am particularly troubled in this case by the findings about mortality rates in VA psychiatric facilities and believe this to be indicative generally of an overall lack of attention paid by the VA to the problems of veterans with psychiatric diagnoses. I plan to pursue actively with VA its plans for corrective action at those facilities identified as having deficiencies.

I understand that resolving problems related to treating the medical or surgical illnesses of psychiatric patients is not easy. It is difficult to recruit and retain adequate numbers of high-quality medical and surgical practitioners at primarily psychiatric facilities, and it is frequently difficult to diagnose the medical or surgical illnesses of psychiatric patients because they sometimes describe their symptoms in ways which differ markedly from the descriptions of non-psychiatric patients. However, this does not mean that the 10.4-percent figure -- which is almost three times as high as for VA general medical facilities -- is not a cause for serious concern. It is indeed.

In its report, VA proposes to institute specific actions to resolve the "likely quality-of-care problems" that were identified. I will press VA to undertake and complete these actions expeditiously -- especially at particular psychiatric facilities. I am requesting the General Accounting Office (GAO) to initiate a review in order to determine if the methodology to be used for follow-up is appropriate, and then to follow VA's action to determine if the follow-up is completed as described, if the actions taken as a result of the follow-up are proper, and if GAO would recommend that other actions be taken.

Regarding a second, related matter, in his letter to me accompanying the mortality study results, Secretary Derwinski stated that "In the narrative summary of this reports, the authors issued this warning: 'No general statement about the quality of care within (VA) can be drawn from these findings'. This statement and other qualifiers led me to a conclusion that this specific effort did not represent a particularly effective use of VA resources." In other words, Mr. Derwinski seems to believe that VA wasted its time and money in conducting this study. I cannot agree with any such suggestion and believe the data developed in this study refutes such a suggestion.

How else would VA have identified those facilities with "likely" problems in quality of care if this study had not been done? I am not aware of any other measurement in the current VA quality-assurance program that has produced comparable data regarding any such deficiencies. Without regard to whether the results can be generalized -- that is, extrapolated to apply to all VA facilities, these findings do imply something about the care given to specific patients in specific facilities -- and especially so regarding medical and surgical care in VA psychiatric facilities. Additionally, although experts in the quality-assurance field assert that there are recognized limitations in using crude death rates as indicators of the quality of care furnished, they further suggest that these types of studies do assist to define where further investigation and possibly corrective action should be pursued.

That is exactly how VA had planned to use and should now proceed to use the study results. I will be pursuing this morning in the course of this hearing several questions I have about VA's proposed followup actions.

Conclusion

We have a number of very important issues of vital importance to our Nation's veterans to cover this morning. I am looking forward to hearing the testimony of each of our witnesses on these issues.

OPENING STATEMENT AT HEARINGS TO CONSIDER VARIOUS MENTAL HEALTH LEGISLATION

BY SENATOR SPARK MATSUNAGA
Senate Veterans Affairs Committee
Wednesday, June 14, 1989
SR-418

Thank you for this opportunity to make a few opening remarks, Mr. Chairman.

First, let me welcome the many distinguished witnesses who are here today from the VA and the national veterans service organizations. I see many familiar faces in the audience. I look forward to reviewing their testimony.

At the outset, I'd like to express my thanks to Chairman Cranston for convening hearings on various bills to improve mental health services for our veterans. It is important that we continue to address the fact that veterans suffer as much from psychological problems as from physiological ones, particularly those who were traumatized by combat or combat-related stress.

I am particularly pleased by the innovative leadership demonstrated by the Chairman and Ranking Minority Member, Senator Murkowski, in proposing measures that would integrate Compensated Work Therapy programs with programs to establish Therapeutic Residences.

Chairman Cranston should also be commended for authoring legislation that would authorize the establishment of mental illness research, education, and clinical centers (MIRECCs). Such centers of excellence will lead to improved quality of care as well as create special learning and teaching environments that will inevitably lead to improved mental health care treatment for veterans.

Finally, I would be remiss if I did not thank the Chairman for including on the agenda my own small bill, S. 192, cosponsored by Senators Cranston and Inouye, which would require the VA to conduct a study of the incidence and prevalence of PTSD and other psychological problems among Asian-American, American Indian, Native Hawaiian, other Native American Pacific Islander, and Native Alaskan Vietnam veterans. This bill is also included as a provision in S. 13. Last year, a similar measure was reported by the Committee in S. 2011, the omnibus veterans' benefits bill, and approved by the Senate. For reasons unrelated to its intrinsic merit, however, the provision did not survive conference with the House. I hope that Congress will act favorably on the measure this year. The information derived from the study may be of crucial importance to the full postwar readjustment of many Vietnam veterans.

Thank you for this opportunity to speak, Mr. Chairman.

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STATEMENT OF SENATOR FRANK H. MURKOWSKI (R-AK)
BEFORE THE COMMITTEE ON VETERANS' AFFAIRS HEARING
JUNE 14, 1989

GOOD MORNING, MR. CHAIRMAN. FIRST, I WISH TO EXTEND A WARM WELCOME TO THE WITNESSES SCHEDULED TO TESTIFY AND TO ALL THOSE IN ATTENDANCE THIS MORNING.

WE WILL HEAR TESTIMONY TODAY PRIMARILY ON ISSUES RELATING TO MENTAL ILLNESS. IT IS IMPORTANT TO NOTE THAT THE VAST MAJORITY OF VIETNAM VETERANS ARE FULLY READJUSTED, AND ARE SUCCESSFUL MEMBERS OF SOCIETY. AT THE SAME TIME WE MUST RESPOND TO THE RELATIVELY SMALL PERCENTAGE STILL FARING THE PSYCHOLOGICAL AFTERMATHS OF THEIR PARTICIPATION IN THE VIETNAM WAR. THOSE VETERANS -- AND CERTAIN VETERANS OF OTHER WARS -- NEED AND AND SHOULD RECEIVE ASSISTANCE FROM VA.

I AM PLEASED THAT MY BILL, S. 846, IS ON THE AGENDA. THE MAJOR GOAL OF THIS BILL IS TO MAKE IMPROVEMENTS IN VA'S COMPENSATED WORK THERAPY (CWT) PROGRAM. MANY OF THE PROVISIONS ARE DERIVED FROM VA'S SUGGESTIONS AND RECOMMENDATIONS. I PARTICULARLY WANT TO EXPRESS MY PERSONAL THANKS TO DR. PAUL ERRERA, MS. JOAN SHELDON, AND MEG O'SHEA OF VA WHO WORKED SO DILIGENTLY WITH MY STAFF ON THIS LEGISLATION.

S. 846 CONTAINS PROVISIONS IN TWO MAJOR AREAS: VA'S HOMELESS CHRONICALLY MENTALLY ILL PROGRAM AND VA'S COMPENSATED WORK THERAPY PROGRAM.

First, the bill would extend for 5 years (through September 30, 1994) VA's authority to provide care and treatment in halfway houses for homeless veterans with chronic mental illnesses. I am proud to be the author of the amendment that established this program and funding for it back in January 1987. So far, this program has been extremely successful in assisting homeless veterans with mental illnesses.

Second, with regard to Compensated Work Therapy, this legislation would, among other things:

- Authorize VA to purchase, lease or otherwise acquire houses to be operated by VA as transitional housing for veterans who are participating in the Compensated Work Therapy program;

- Authorize VA to establish nonprofit corporations to provide a flexible funding mechanism for VA to conduct Compensated Work Therapy and transitional housing programs.

VA's Compensated Work Therapy program was established to provide vocational skills in a sheltered environment for veteran patients. VA contracts with community businesses, industry, or nonprofit corporations to provide work opportunities for veteran patients. In fiscal year 1988, VA operated 45 such programs which provided work for 6,581 veterans. Patients were paid a total of $1.8 million. Nearly 90 percent are psychiatric or substance abuse patients.

One of the goals of this bill is to link VA's Compensated Work Therapy program with a new program of therapeutic housing. My bill would authorize the Secretary of Veterans Affairs to use existing Compensated Work Therapy revolving fund monies to purchase, lease, or otherwise acquire houses to be used as therapeutic transitional housing only for veteran patients participating in the Compensated Work Therapy program. Houses could be purchased from those which had been acquired as the result of foreclosure.

This provision emphasizes 1) a work-for-pay program which focuses on skills training, and developing good working habits, as well as strengthening the veteran's self-esteem; and 2) a therapeutic residence which provides the opportunity for veterans to live independently, including learning how to manage money. Veterans would be required to pay rent, cook, clean house, operate appliances, and make minor household repairs.

S. 846 would authorize VA to establish nonprofit corporations to provide a flexible funding mechanism for the conduct of VA Compensated Work Therapy programs. Specifically, the nonprofit corporation would be able to accept gifts and grants which would be transferred to the revolving fund account enabling VA to purchase homes and administer the Compensated Work Therapy and transitional housing program.

During my review of the written testimony to be presented today, I noted that VA as well as all the other witnesses support my legislation. Thank you, Mr. Chairman.

STATEMENT BY SENATOR STROM THURMOND (R-SC) BEFORE THE VETERANS AFFAIRS COMMITTEE REFERENCE MENTAL HEALTH LEGISLATION, JUNE 14, 1989, SR-418, 9:00 AM.

MR. CHAIRMAN:

It is a pleasure to be here this morning to receive testimony on legislation which addresses Post Traumatic Stress Disorder, mental illness, the homeless, and compensated work therapy at Department of Veterans Affairs medical centers. I appreciate your scheduling this hearing.

Several of the bills we will be receiving testimony on today involve the expansion of existing programs and services at the Department of Veterans Affairs. One bill would grant entitlement to care for the treatment of Post Traumatic Stress Disorder without an adjudicatory determination of service-connection. Another would provide for a comprehensive study of the psychological problems of certain groups of Vietnam veterans. Lastly, one measure would substantially expand the Compensated Work Therapy Program.

Mr. Chairman, in considering these bills, we need to strive to be as objective as possible. In doing so, I believe we should always keep in the forefront of our minds the question--Does this represent the wisest use of limited Federal resources? This is particularly true given the current medical care funding situation at the Department. In considering the substance of these bills, I trust the Committee will carefully consider the merits, in light of the money available.

Again, Mr. Chairman, I appreciate your scheduling this hearing. I must leave now to attend another meeting.

STATEMENT OF
JOHN A. GRONVALL
CHIEF MEDICAL DIRECTOR
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
JUNE 14, 1989

Mr. Chairman and Members of the Committee:

I am pleased to be here today to discuss a number of legislative proposals primarily related to the care, treatment or study of veterans with mental illness disabilities. Specifically, the various proposals would expand VA compensated work therapy programs aimed at chronically mentally ill veterans, address issues associated with post-traumatic stress disorder, extend VA's homeless chronically mentally ill program, and authorize VA to create mental illness research, education, and clinical centers (MIRECC'S). Although unrelated to mental health issues, you also asked that we comment on your proposal to transfer supervision of the security and law enforcement functions at VA medical centers from the facility directors to the Assistant Secretary assigned management, productivity, and logistic support functions.

MIRREC'S -- (S. 86)

S. 86 would call for the establishment and operation of up to five VA health care facilities as centers for mental illness research, education, and clinical care (subject to the appropriation of sufficient funds for that purpose.) This bill is substantially identical to a provision in S. 2011 as passed by the Senate last year.

As we stated in testimony before the committee one year ago, it is not clear that VA needs a statutory basis to start up such a "MIRECC" program. Also we oppose language that would require establishing an automatic priority for any category or source of research proposals, as this measure proposes.

We estimate that establishing the MIRECC program contemplated by this bill would entail costs of $3.1 million in Fiscal Year 1990 and $20.9 million over four fiscal years.

HCMI PROGRAM -- (S. 405 & S. 846)

Both S. 405, and section 3 of S. 846, would extend the authorization for VA's program for providing community-based contract care and rehabilitative services for homeless chronically mentally ill (HCMI) veterans. Among its provisions, S. 405 would extend the program for three years, until September 30, 1992, and would include chronically mentally ill veterans who have service-connected disabilities rated at least 50% within the scope of program eligibility. Those individuals were accorded eligibility when Congress first authorized the program in 1987. S. 846 would simply extend the program authorization for five years. Although we would not oppose the enactment of S. 405, considerations of program continuity -- eliminating some of the uncertainty regarding the program, and the attendant difficulty of recruiting and retaining staff -- makes a five-year extension of this successful pilot a more desirable option.

The HCMI program had its genesis in Public Law 100-6 in 1987. The program is currently authorized by section 115 of Public Law 100-322, and funding was most recently authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1988, Public Law 100-628. Although we have operated the HCMI program for less than two years, it has had noticeable successes, assisting in the rehabilitation of chronically mentally ill veterans in some 43 different locations. Outreach teams, usually consisting of two health care professionals, make contact with individual veterans wherever they may be living in the community, often on the streets and in shelters. They initially establish eligibility and then take the veteran, if willing, to a VA health care facility for a complete physical and mental health examination and evaluation. If appropriate and eligible, the veteran is placed in a community-based residential psychiatric treatment program pursuant to a contract between VA and the treatment facility. In addition to treatment, emphasis is placed on connecting the veteran to other non-health-care resources in both the VA and in the community at large.

Most veterans entering the HCMI program achieve some of the goals set for them when they enter. Most are discharged from the program with their health care problems stabilized, and they are not homeless. Considering the fact that the program is aimed at an extremely difficult population to serve, the results of the program have indeed been excellent. We support continuation of the program.

VA estimates that continuation of the HCMI program at current operating levels, would cost approximately $13.9 million in Fiscal Year 1990, and $69.3 million over five fiscal years.

COMPENSATED WORK THERAPY -- (AMENDMENT TO S. 13 & S. 846)

Mr. Chairman, I turn next to two measures directed at enhancing our authority to rehabilitate patients, particularly chronically mentally ill veterans, through work-for-pay programs. Therapeutic work experiences have proven to be beneficial to those patients' physical and mental health, and they can be critical to helping them make the transition from institutional care to independent living in the community. Both your amendment to S. 13, and S. 846, would broaden our authority to conduct compensated work therapy (CWT) programs. We support those provisions. Both measures would also facilitate the development and operation of so-called "therapeutic residences" to provide transitional housing for patients in those compensated work therapy programs, but they represent different approaches. We would support legislation that provides the basis for a therapeutic residence pilot program. Although your amendment to S. 13 contains several creative, very helpful concepts, we have some fundamental concerns about the bill. The provisions of S. 846, in our view, would provide us with greater flexibility to design workable programs, and we support it.

Both measures would authorize VA to provide therapeutic work opportunities in our own health-care facilities, and through arrangements with other government installations. Existing law authorizes us to obtain work agreements only with private businesses and other non-federal sources outside the VA. There are many opportunities for work in VA and other federal agencies, however, and allowing patients to perform this work can be very beneficial, particularly in those locations where, due to the small size of the community, work opportunities with private business sources are simply unavailable. Thus, we support these provisions.

S. 846 would authorize the Secretary to establish therapeutic residences to serve as transitional housing for veterans who are participating in VA's compensated work therapy or incentive therapy programs. Only participants in those programs, and a house manager, could live in such facilities. Each veteran would be required to pay rent, and homeless veterans would be given priority for spaces in the home. The bill would authorize VA to use monies in the Special Therapeutic and Rehabilitation Activities Fund (STRAF) to acquire and operate the residential housing, and all rents paid by veterans would be placed in the same fund. It would also authorize use of houses already owned by VA as a result of defaults on loans guaranteed or made under our home loan program, provided funds are transferred from the STRAF to the Loan Guaranty Revolving Fund to pay for such properties. Although S. 846 provides authority to purchase properties from HUD as well as VA, we would certainly give preference to purchasing our own properties. This would eliminate the possibility of having to dispose of HUD properties in the event the house was no longer needed.

S. 846 would also permit us to to enhance our work-for-pay programs and provide funds for the therapeutic residence program through creation of nonprofit corporations. Similar in concept to the nonprofit research corporations authorized by Public Law 100-322, the corporations could serve the VA as a vehicle for procuring and administering compensated work therapy contracts, and as flexible funding mechanisms, soliciting and administering donations from private and nonprofit sources to support the therapeutic residence program. In particular, we anticipate being able to receive funds from nonprofit organizations that are currently unable to make donations to Federal programs. The bill would permit transfer of funds obtained by such corporations into the STRAF. It is not our intent that the nonprofit corporations would borrow funds from commercial lenders. We expect that STRAF funds as well as private donations and rental payments would be adequate to purchase outright the number of houses needed for this program.

Mr. Chairman, if S. 846 were enacted, we would anticipate implementing its therapeutic community provisions on a relatively small scale using funds in the STRAF. Our initial goal would be to ascertain whether establishing such "therapeutic residences" assists chronically mentally ill veterans to make the transition from institutional care to independent living in the community. The proposal appears to have potential to achieve that goal and to do so in a very cost-effective manner. Establishing such therapeutic communities would allow VA to rehabilitate patients by assisting them to learn independent living skills at the same time that they are participating in a work-for-pay program. It is well established that giving patients structured work activity, and requiring them to take on responsibilities like paying rent (presumably using funds earned in the compensated work therapy program) can be invaluable rehabilitative experiences, and provide them a basis to provide for themselves. Moreover, the use of rent payments would provide partial support for operating the residence. The VA medical centers that will become sponsors of the programs will provide assistance within their available resources. As a result, we do not expect this program to increase costs. Thus, we support S. 846 with some modifications.

We would prefer to conduct a program as a three to five-year pilot at ten to twenty-five sites, and then evaluate the program before proceeding any further. We suggest that the bill be amended to reflect this. Moreover, we recommend that you delete section seven requiring a transfer of funds from the VA medical care appropriation. As I stated earlier, VA anticipates implementing the program on a small scale using STRAF funds. We prefer to maintain our resources in medical care for the pilot program on the chronically mentally ill.

Your amendment to S. 13 takes a different approach. It would mandate the establishment of a pilot program which would rely entirely on nonprofit corporations (to be established at the initiative of VA officials) as vehicles for not only the creation, ownership and operation of the residences, but also for the conduct of compensated work therapy programs. Although the amendment to S. 13 seems aimed at creating a therapeutic residence program operating independently of VA resources, the model invites reliance on VA staffing and expertise, as well as VA financial support. Moreover, the proposal contemplates a fundamental change in VA's CWT program. Although the measure has many positive elements, it is not clear that it is a cost effective method for conducting CWT activities, or operating therapeutic residences.

Your amendment would direct creation of a five-year pilot program under which VA would "encourage and participate" in the creation of nonprofit corporations which would conduct CWT programs for VA, and at the same time operate therapeutic residences for veteran patients who are participating in CWT programs. Under the proposal, VA would enter into contracts with nonprofit corporations to conduct CWT programs on our behalf. The corporations would procure and enter into contracts with businesses in the community for work for patients, transport patients to worksites if necessary, pay patients, and obtain materials necessary for work. In short, the corporation would do whatever is necessary to operate a CWT program.

A condition of all contracts would be the corporation's agreement to operate a "therapeutic residence" for patients participating in CWT programs. VA would provide the corporation with initial financial assistance in obtaining the residence either through a loan (up to 25% of the cost, or one year's rent), an advance payment on the contract, or by providing a house which VA has obtained through foreclosure on a loan made or guaranteed by VA. The corporation would be required, however, to pay back the loan, or pay for the use of the home VA provides.

The amendment would authorize VA to assist the nonprofit corporation in the purchase or lease of a therapeutic residence by making advance payments on the contract for CWT services, The bill would require contract safeguards to assure that VA recoups any funds it has loaned or advanced in the event the house ceases to be a therapeutic residence. Funds to be advanced or loaned to the corporation would be placed in escrow until the corporation is able to demonstrate that at least 25% of the operating expenses of the therapeutic residence, except for amounts veterans pay in rent, can be met with funds obtained from non-VA sources. The measure provides authority to transfer funds in our General Post Fund to the STRAF for use in making loans or advance payments.

Under the pilot, VA would also lease 10 houses obtained through foreclosure, to participating corporations for use as therapeutic residences. In return, the corporation must pay VA 60% of all rents it collects from patients living in the residence to reimburse the Loan Guaranty Revolving Fund. If and when the lease is terminated, the house would return to VA for ordinary disposal under the loan guaranty program.

Mr. Chairman, we applaud the innovative approach reflected in this measure and the concern you expressed that this legislation not add to the fiscal and recruitment pressures under which VA has been operating. However, although our opportunity to study this complex bill in depth has been limited, it is clear that the bill's reliance on nonprofit corporations does not render it "fiscally neutral."

First, we note that the bill's fiscal underpinning is the requirement that VA contract with nonprofit corporations to run VA's CWT program. Thus, VA is to pay the nonprofit (the bill does not specify whether from the STRAF or from medical appropriations) to carry out programs VA medical centers have been operating effectively for years. CWT contracts have yielded monies which have enabled the STRAF to grow, thereby providing funds for establishing new rehabilitative projects; such funds would not inure to the STRAF under the bill. The bill also provides that VA, as partial payment under the contract, may provide the corporations a broad range of in-kind assistance. It does not appear that the corporation would have to make much use of the employment authority provided for in the bill, in light of the in-kind assistance it can obtain from VA. VA would, in fact, subsidize the corporation's start-up and operations in several respects, as described above.

Thus, the bill makes it altogether possible, if not likely, that the corporation would be highly dependent on VA and VA resources, while at the same time it would be beyond VA's authority to control. This is particularly troublesome in connection with its proposed role of running a VA program -- compensated work therapy. We are concerned that VA would, in effect, be contracting out the management of a VA program largely to fund the operation of therapeutic residences. This change would have substantial implications, not the least being the depletion of the STRAF as a source of support for CWT programs outside this pilot.

We agree that it would be desirable to have nonprofit corporations play a role in establishing therapeutic residences. We do not believe that the amendment to S. 13 provides the most effective vehicle to achieve that end, however. We recommend that VA be given the more flexible authority proposed in S. 846, consistent with the amendments we have recommended, to develop pilot or demonstration therapeutic residence projects. If those efforts prove successful, they offer the best promise, in our view, of providing models for the private sector to emulate.

POST-TRAUMATIC STRESS DISORDER -- (S. 13 & S. 192)

Mr. Chairman, there are four proposals before you which address different issues associated with post-traumatic stress disorder.

Care for Combat Veterans with PTSD

Section 201 of S. 13 would direct VA to furnish hospital care and outpatient treatment on what amounts to a priority basis to all veterans who served in combat, and who seek care for post-traumatic stress disorder (PTSD) related to such service. To receive this priority under the bill, a designated mental health professional must diagnose PTSD and determine that it is related to such service. The measure would require that we furnish care for PTSD as if the disorder had been formally adjudicated as service-connected, even though a formal adjudication of service-connection would not be required. We oppose this provision.

Mr. Chairman, we have the greatest compassion for those who served in combat and are now suffering from PTSD as a result of that service. In the years since PTSD became a widely recognized disorder, the VA has significantly expanded the availability of care to those who are suffering from it. We will continue in our efforts to expand programs for PTSD, and to provide all necessary care for that disorder. We oppose legislation which would have the effect of assigning a statutory priority on the basis of a particular diagnosis.

In our view, enacting this measure would have the undesirable effect of blurring the important distinction between service-connected and nonservice-connected veterans. Moreover, by increasing certain veterans' access to care, it would decrease other veterans' access, apparently without regard to the relative need for that care. If PTSD treatment needs a greater priority in the VA, the Department should have the opportunity to devise ways of meeting this need within the total health care system, without legislative directive.

Further, we oppose this section because it would treat veterans as service-connected when they have not been formally so adjudicated. The adjudication process -- to be bypassed under the proposal -- is not a mere formality, but a careful deliberative process which necessarily includes an analysis of military records. In contrast, establishing "service-relatedness" under the proposal must rely almost entirely as a practical matter on the patient's history. This measure would effectively require the patient's physician, in weighing that history, to be both adjudicator and clinician, roles which potentially conflict. We strongly advise against this departure from VA's longstanding adjudicative process, which, in the case of PTSD claims for example, has resulted in a very significant percentage of awards of service-connection.

It is certainly important that VA respond effectively to the needs of veterans who continue to suffer from problems having their origin in service. If we are not meeting that need, we submit that this measure is simply not a sound remedy. We ask that the Committee forbear from enacting a provision which offers no assurance that it will fulfill its "promise," and which may well be a disservice to chronic mentally ill and other veterans who could lose access to VA care as the Department attempts to meet a proposed new mandate.

We estimate the cost associated with enacting section 201 would be approximately $17 million in Fiscal Year 1990 and approximately $81 million over the next five fiscal years.

Special Committee on PTSD

Section 202 of S. 13 calls for the Special Committee on PTSD, established in accordance with Public Law 98-528, to provide three reports on PTSD to the Secretary and the Congressional Veterans Affairs Committees. One report would evaluate the results of a previous study on the prevalence and incidence of PTSD among Vietnam veterans. The others would update its own previous reports on VA's capability to treat veterans with PTSD. This section also requires the Secretary to submit comments on these reports to the Committees. We see no need for this legislation.

Public Law 98-528 does not require VA to disband this committee. And in view of the Special Committee's expertise and long involvement in this area we intend to continue to benefit from its insight and recommendations. However, the proposed reporting requirements, which would direct the Special

Committee to report concurrently to the Secretary of Veterans Affairs and the Senate and House Veterans' Affairs Committees, with the Department's comments submitted at a later date, are problematic from both a constitutional and a policy standpoint. It is our understanding that the Department of Justice has provided a report on S. 13 which discusses what appear to be constitutional infirmities in this reporting scheme. Let me add, however, that the reporting requirement would also seem to defeat the very benefits the committee is established to provide -- to advise Department officials in a manner permitting the formulation of changes in VA policy (as part of the budget process, for example); at the same time it would have the effect of eroding the Secretary's authority. We strongly oppose this provision.

We estimate that the cost of section 202 would be $204,000 in Fiscal Year 1990 with a total cost of $644,000.

PTSD Study of Certain Ethnic Groups

Section 203 of S. 13, and S. 192, would direct VA to conduct a study of the prevalence and incidence of post-traumatic stress disorder (PTSD) and other psychological problems among Asian-American, American-Indian, Native-Hawaiian, other Native-American Pacific Islander (including American Samoan Native), and Alaska Native Vietnam veterans, and of the effects of those problems on these veterans. The bill would require that particular attention be given to women veterans and disabled veterans. It would also require that a report containing the results of the study be submitted to the Veterans' Affairs Committees of Congress by October 1, 1991. We oppose this provision.

The recently-completed National Vietnam Veterans Readjustment Study has given VA much insight regarding the prevalence and incidence of PTSD and other psychological problems resulting from service in Vietnam. That study included Native American veterans in its samples and provides valuable new information. However, we believe it would not be cost-effective to conduct a similar study focused solely on a particular subgroup or groups. Special sampling techniques were used in the National Vietnam Veterans Readjustment Study to gain information on specific cultural and racial groups, e.g., Blacks, Hispanics, women, and the disabled. Although the proposed study could yield some new data, we believe that the findings of the recent study are applicable to Native Americans and other groups.

Based on what we have already learned about the incidence and prevalence of PTSD, we do not believe the proposed study is needed to assist us in responding to these veterans' clinical needs. Weighed against competing demands for funding, the proposed study would not be a cost-effective undertaking.

We also would anticipate difficulties in using special sampling techniques to determine the prevalence and incidence of psychological disorders among subgroups of women and disabled veterans in the larger group of Native American veterans specified in this legislation. The size of those subgroups is so small that obtaining an adequate sample size to gain valid data may not be possible. Finally, designing and conducting the proposed study and reporting its results to Congress by October 1, 1991, would be very difficult and may well increase the cost of such an undertaking.

We estimate that enactment of section 203 would result in costs of approximately $1.7 million.

PTSD Programs Funding

Section 204 of S. 13 would require that we submit to Congress, in conjunction with budget submissions for each fiscal year, amounts estimated to be obligated for various items related to PTSD treatment, education, and research. These items would include: payment of disability compensation for PTSD; the treatment of veterans for PTSD by or at VA's expense; PTSD education, training, and research; and the National Center on PTSD's operation.

We agree that the data sought by this measure would be of interest. However, such data are neither readily available nor retrievable. Estimating future obligations for various activities related to PTSD would depend on the availability of historical cost information. Our existing national databases, monitoring systems, and reporting mechanisms are not designed to provide this historical information, and attempts to retrieve such data in certain categories would not be reliable or verifiable even if major efforts were made to make significant revisions to the data collection systems. Attempts to implement this provision would also require that resources be diverted from other, more patient-care oriented activities.

Given our mandate in law to operate a complete medical and hospital service for veterans, we strongly oppose budgeting by diagnostic categories. In maintaining a comprehensive health-care system for the care of veterans, separate diagnosis-related budgeting and reporting would emphasize care focused solely on the disorder instead of care for the whole patient. To implement these requirements would entail revamping VA patient databases and accounting systems and entail significant additional costs without a foreseeable benefit to our patients.

SECURITY SERVICES -- (S. 13)

Section 221(a) of S. 13 would assign the functional and technical supervision of the performance of security and law enforcement functions to the Assistant Secretary assigned management, productivity, and logistic support functions. Currently, VA medical facility officials are assigned this responsibility, and the Central Office security staff is part of the Veterans Health Services and Research Administration. This provision would thus be a major departure from the traditional relationship between VA medical facilities and their police.

Past problems with VA police recruitment, hiring, training, and retention, are, we assume, the reason this provision is being considered. After these problems were identified in 1988 Inspector General audits, however, VA implemented a number of corrective measures. These include more rigorous preemployment screening and special background checks for all current police. Certainly continued improvement is vital, but for Congress to abruptly shift responsibility for the management and direction of this program from the Chief Medical Director could complicate our remedial efforts.

VA police are a vital part of the patient care team and have been invaluable in quelling disturbances and resolving episodes of disorderly or assaultive conduct. Their goal is to protect the patient care staff and veteran patients alike while exercising authority with understanding and restraint. That goal, in our view, can be more effectively achieved while security functions and policies remain within the control of the Veterans Health Services and Research Administration. This provision may dilute the Chief Medical Director's authority to determine security policy and direct security operations, and as such, have an adverse effect. Moreover, we oppose legislative efforts to reassign particular management functions within the Department. From VA's perspective, such action represents an intrusion on the very discretion Congress has sought to have the Secretary exercise.

Section 221(b) of S. 13 would require VA to provide the Congressional Veterans' Affairs Committees with a report containing: (1) the Secretary's plan for improving the training, recruitment, and pay of VA security and law enforcement personnel, and (2) the Secretary's assessment of the need for establishing a policy on the issuance of weapons (firearms) in certain high crime areas and the advisability of reducing VA police services at some VA facilities in order to increase those services at VA facilities with significant security problems. VA does not object to this provision. We also understand that the Department of Justice will be providing you with a report on this provision recommending a minor modification in the bill to assure that VA consults with the Attorney General on development of any regulations which may be recommended in this report. We have no objection to such a requirement which is consistent with the consultant relationship we have had over the years.

If enacted, section 221 would result in no new costs to VA.

Mr. Chairman, this concludes my prepared statement. My colleagues and I would be pleased to respond to any questions you may have.

JUN 21 RECD

DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION

WHITE PAPER

COMPENSATED WORK THERAPY/THERAPEUTIC RESIDENCE (CWT/TR)

During the Senate Hearings on June 14, 1989, clarification on the issues discussed in this white paper was requested by Senator Cranston. Those issues questioned were: comparison of costs between S.13 and S.846; funds available in the Special Therapeutic and Rehabilitation Activities Fund (STRAF); and projected costs of therapeutic housing. Projecting the costs of implementing the Compensated Work Therapy/Therapeutic Residence (CWT/TR) demonstration project presents a series of interesting challenges. A proposal previously developed by VA included three models of therapeutic housing:

1) Purchase of houses through a non-profit corporation

2) Purchase of houses by the VA

3) Use of underutilized space within VA

For models 1) and 2), we anticipated the need for supplemental funds (gifts, grants and donations) other than the STRAF account.

S.13 authorized therapeutic housing through non-profit corporations only, whereas S.846 authorized the purchase of houses either by the VA or through a nonprofit corporation. In addition, two models for CWT were identified in S.13 (CWT programs run by the non-profit corporations) and S.846 (CWT is maintained as a separate program within VA.)

CWT/TR Funding Services

At the current time, we can identify up to $75,000 in VACO STRAF to assist in the development of CWT/TR demonstration programs during the first year. The major funding sources must come from the local medical facility. They will depend on the availability of locally generated STRAF funds and the facilities' ability to solicit donations, gifts and/or grants. There are no plans to transfer funds from one medical facility STRAF account to another in order to purchase homes.

In order to clarify VA's proposed funding sources, the following three scenarios will demonstrate the significant differences found at Palo Alto, American Lake and Pittsburgh. In all three sites, nonprofit corporations have been used; however, only at Pittsburgh could the VA have funded a similar housing program without the use of a non-profit corporation. It is important to note that the medical centers' location relative to the economy is a significant factor in their ability to purchase houses and how many houses they can afford to buy.

1. Palo Alto

At one time, a Palo Alto non-profit corporation owned six houses that were acquired as repossessed VA properties. These houses were renovated with the help of patient labor who were participants in CWT. Eventually, five of these houses were sold due to deteriorating neighborhoods. Acquisition costs of two other homes at the same facility were financed with funds from the Department of Housing and Urban Development (HUD). Additional financing was secured in below market rate loans from the Low Income Housing Fund of San Francisco, CA. Renovation costs were secured from Community Development Block Grants. Finally some renovation costs, repairs and maintenance, and replacements of appliances were accomplished from private foundations. The supervision of the therapeutic residences is managed by the Program Manager of CWT. The community health nurse and other therapists assigned to CWT provide consultation and support. Financial controls for the residential component is handled by the financial controller for the nonprofit corporation. Funds to provide operational costs are derived from rent and where needed subsidized from CWT STRAF funds.

At the Menlo Park Division of Palo Alto, two different corporations provide the structure for the CWT program and the housing program. Apparently in the state of California, in order to qualify for certain funds, the corporations for the work programs had to be separate from the residences. Both non-profit corporations have their own separate Boards of Directors; however, staffing, space, utilities, etc., overlap. The following information was provided by the non-profit corporation's bookkeeper (same bookkeeper for both non-profit corporations).

Between July 1, 1988, and June 30, 1989, the expenses of 1.5 houses were as follows:

Rent Collected	$17,998	with interest	$18,083
Expenses			
Utilities	$2,937		
Maintenance	225		
Supplies	138		
Telephones	913		
Bookkeeping	1,100		
Depreciation	4,337		
Insurance	686		
Real Estate Taxes	305	(reduced)	
Interest/Mortgage	7,814	Total	$18,445

Deficit of $362 (borrowed against the mortgage)

It is important to note that as a result of the residences and CWT program at Menlo Park being run by two nonprofit corporations, the following expenses have also been incurred:

	FTEE (non-Federal)	
Bookkeeper	1	
Secretary	1	staffing costs $60,000
Asst' Foreman	1.0	
Foreman	1.0	
Contract Procurement Agent	1.0	paid $55,000 which is a percentage of contracts
Total staff costs		$115,000

Liability (Fireman's Fund) - 1988 $17,000
Housing
Vehicles has increased in 1989 to $24,000
Workshops

Since CWT is under a non-profit corporation (the Veterans Workshops), they must pay $7.50 per $100.00 paid to patients for workman's compensation. In 1988, this cost them $12,000.

Vehicles - Veterans Workshop owns seven vehicles. Most expenses are covered by transportation fees.

2. American Lake

American Lake has a non-profit corporation only for the residences. The acquisition of the "J" street residence was from a repossessed VA loan guarantee house financed by the VA Loan Guarantee Division and the Seattle VARO. Due to the financing, the loan discount was unavailable. The cost of the house was $30,000. Cost of remodeling was $15,000 which is being sought from a HUD grant for Transitional Housing under the McKinney Act.

Projected Annual Operating Costs:

Property Taxes (exempt)	
Insurance	$ 500
Utilities	1,800
Maintenance and repair	600
Staff	-0-
Program manager (free rent)	
Mortgage	3,159
Total	$6,059

Method of Payment

Income statistics are based on a gross monthly income of $750 per patient. Thirty percent of the monthly income must be used as rent (HUD regulations). Therefore, four patients (plus program manager) per house will yield $988 per month for a total annually of $11,856. Annual operating costs are $6,059. The financial cushion will help in case of vacancies and other unforeseen expenses.

In the American Lake model, no staff are funded for the non-profit corporation. Since CWT is in the VA, workman's compensation, liability, and vehicle insurances are unnecessary. As a result, there are significant financial savings allowing for future expansion.

3. Pittsburgh

Although the Pittsburgh model is based on a non-profit corporation, a similar program could have easily been accomplished within VA, using STRAF funds. In this scenario, four row houses were purchased through the VA's Home Loan Guaranty Program at a discount rate. The American Legion paid $20,000 for all four homes and allocated $5,000 for renovations. The patients provided the labor for the renovations without compensation.

Annual Operating Costs:

Taxes (exempt)
Furniture and Supplies (donated)
Utilities $4,000 per year
Maintenance and repair (donated)

Income - $60.00 per resident/per month - 9 patients $540
Total $6,480 per year

In this particular program, the American Legion has not made an attempt to "break even" in terms of financing. However, over a long period of time, they anticipate increasing the rent so there will not be a deficit in operating expenses.

In this scenario, the American Legion has not placed a time limit on how long the veteran can remain in the home. While program officials anticipate turnover as residents gain employment, they may consider this residence as a permanent home.

Comparison of S.13 and S.846

These three models demonstrate some of the difficulties in trying to project a budget which accurately reflects costs for the demonstration programs we hope to initiate. The range is

5.

from $459,880 at Palo Alto to $6,059 at Pittsburgh. Major expenses are found in workman's compensation, liability, insurance for vehicles, and staffing costs. These were not present at American Lake and Pittsburgh.

It is somewhat difficult to compare S.13 and S.846 in terms of cost because many of the same provisions are authorized in both bills, i.e., non-profit corporations. VA's major concern with S.13 is the clause which places CWT under non-profit corporations. If Palo Alto is any indication, there are significant addition overhead expenses when CWT is placed under a non-profit such as:

Workman's compensation	$12,000	
Liability (includes housing vehicles and workshops)	$24,000	(for 1989)
Additional paid staff	$115,000	
Total	$151,000	

Every non-profit corporation will need to pay insurance for houses if they go into the therapeutic residency program. However, workman's compensation and liability insurance is primarily a result of having CWT under the non-profit. It is important to note that under either structure, VA staff provides supervision and training. Workshops are located in VA medical facilities, most utilities are provided by VA and general maintenance is provided through VA - even though there are the additional high expenses in the non-profit corporations.

Medical centers in rural settings may not find it advantageous to establish non-profit corporations. Because of limited community resources, the major funding sources may be their own STRAF and/or donations. A non-profit corporation might only incur additional expenses without added benefits.

The actual extent of the proposed demonstration project (i.e., number of sites and houses) would be made after "Requests for Proposals" had been returned by interested field facilities and a determination made as to the level of CO financial support required.

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STATEMENT OF

THE AMERICAN PSYCHIATRIC ASSOCIATION AND THE
NATIONAL ASSOCIATION OF VA CHIEFS OF PSYCHIATRY

ON

VETERANS' MENTAL HEALTH LEGISLATION

PRESENTED BY

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IMMEDIATE PAST PRESIDENT, NATIONAL ASSOCIATION OF VA CHIEFS OF PSYCHIATRY
CHIEF OF PSYCHIATRY, ANN ARBOR VA MEDICAL CENTER
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DEPARTMENT OF PSYCHIATRY
MEMBER, SPECIAL COMMITTEE ON PTSD

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

JUNE 14, 1989

Mr. Chairman and Members of the Committee, I am Spencer Falcon, M.D., immediate past President of the National Association of VA Chiefs of Psychiatry (NAVACOP) and a member of the American Psychiatric Association (APA), a medical specialty society representing over 35,000 psychiatrists nationwide. I am also Chief of Psychiatry at the Ann Arbor VA Medical Center, Associate Chief of Adult Services, University of Michigan, Department of Psychiatry and a member of Special Committee on Post-Traumatic Stress Disorder. I am pleased to appear before the Committee to present the views and concerns of the APA and NAVACOP regarding S. 13 (legislation revising health care programs for veterans); S. 86 (legislation creating five mental illness research, education, and clinical centers (MIRECC's)); S. 405 (legislation extending the VA's program providing community based residential treatment for homeless chronically mentally ill veterans); and, S. 13 amendment 124 and S. 846 (legislation to improve the compensated work therapy services to homeless veterans).

Post-Traumatic Stress Disorder
S. 13 (Section 201, 202, 203 and 204)

In regard to Post-Traumatic Stress Disorder (PTSD) and Senate Bill S.13, we would like to express support for this bill and discuss its relevant Sections (201, 202, 203, and 204) in accord with the new information provided by the National Vietnam Veteran's Readjustment Study (NVVRS). Section 201 -- Care for Combat Veterans with Service Related PTSD -- provides for increasing the eligibility to include those veterans even if such disorder had not been determined to be service connected. The need for such a bill is clearly illustrated in the results of the NVVRS, which found that 15.2% (480,000) of all male Vietnam theater veterans currently have PTSD. This current prevalence rate is noted in a very strong methodologic basis and compares well with the previous utilization studies done by the Special Committee on PTSD (the Mental Health Outpatient Study), wherein 19.8% of all male Vietnam era veterans seen in veteran centers and outpatient mental health programs at VA medical centers had PTSD as a diagnosis. Despite this, the NVVRS data show that approximately 90% of the estimated 480,000 veterans with current PTSD have never used VA mental health resources. These findings support the contention of many practitioners in the field that there is a substantial unmet need of veterans suffering from PTSD and that a component of the impediment to their receiving this care is the eligibility requirement that is addressed on the basis of Section 201. In addition, the GAO, in a report released 12/29/88, stated that the VA cannot ensure that the veterans are given accurate and uniform disability ratings, further necessitating the need for expansion of eligibility as provided in Section 201.

As the Special Committee and others have looked at the utilization of care among this veteran population, several facts stand out. Among Vietnam veteran outpatients seen exclusively at VAMCs or vet centers during the

Mental Health Outpatient study, 28.4%, and 41.6%, respectively, were hospitalized at least once within six months before or after the index month of outpatient treatment. Among those veterans seen at both VAMCs and vet centers, 42.9% were hospitalized at least once. These findings, along with the fact that the mean level of adaptive functioning (an indication of the severity of the illness) is more impaired among veterans with PTSD co-diagnosis is suggestive, if not confirmatory, of the severity of this illness. These inpatient hospitalization rates are an indication that veterans suffering from PTSD have substantial need for a full array of mental health services.

We support the idea of continuing the ongoing report relationship between the Special Committee, the VA, and Congress, contained in Section 202. During the July 14, 1988 Senate Committee on Veterans' Affairs hearing on PTSD, Senator Cranston asked the Special Committee to interpret the NVVRS study conducted by the Research Triangle Institute (RTI). The Special Committee has completed and submitted its initial report on the NVVRS to the Chief Medical Director. The current report addresses the following aspects of the NVVRS: methodology, women war-zone veterans, special populations (minorities and physically handicapped), diagnostic comorbities with PTSD and utilization of VA resources by veterans with PTSD. This report also contains a response to another Congressional inquiry. The Senate and House VA Committees jointly requested that the Special Committee review the recently published American Legion studies on the impact of combat and agent orange exposure on the physical and mental health of Vietnam veterans. We believe that in order to continue to develop sound public policy in the area of PTSD treatment methodology, continued reporting by the Special Committee is a necessity.

Section 203 of the Senate bill addresses concerns regarding problems among special populations of combat veterans. One of the findings highlighted in the NVVRS was the prevalence of illness among women Vietnam veterans and special populations with PTSD. There appears to be a higher current PTSD prevalence rate for black and Hispanic, than for white, theater veterans. There were 3.14 million soldiers who served in Vietnam. Of that total, 11% (350,000) were black and 5% (170,000) were Hispanic. The NVVRS indicates the black and Hispanic theater veterans have significantly higher prevalence rates of current PTSD and lifetime PTSD when compared to white theater veterans; a current prevalence rate of 13.7% for white theater veterans, 20.6% for black theater veterans, and 27.9% for Hispanic theater veterans. With the addition of exposure to war-zone stress, the prevalence rate of PTSD goes up considerably with 34% of white theater veterans, 38.2% of black theater veterans and 48.4% of Hispanic theater veterans affected. The difference of prevalence of PTSD between white and black theater veterans appears to be statistically accounted for by high exposure to combat-zone stress. Questions remained unanswered regarding the higher current prevalence rates for Hispanic and other populations. Another important finding in this area was that service-connected veterans with physical disabilities (SCPD) were twice as likely to have PTSD than non-SCPD combat veterans. Attention and resources need to be directed by the Veterans Administration toward research and evaluation of the needs of the special

Vietnam veterans (i.e. service connected physically disabled, black, and Hispanic) populations. This should be a high priority for the VA that receives ongoing emphasis. Given the high prevalence of PTSD among the special populations assessed in the NVVRS, we would expect much to be gained in further evaluation of other special populations, as provided in Section 203.

As physicians and mental health practitioners, we have come to know more about PTSD, we have learned that it is frequently a chronic condition. Findings from the study show that about one half of male theater veterans (42.9%) and one third (31.6%) of female theater veterans who ever had PTSD still have it today. These findings support the concept of PTSD as a chronic disorder. Corrective treatment will require ongoing contacts with the VA or other mental health facilities. As we look at the life history of veterans, we see recurrences of symptomatology or continuation of symptomatology over decades. This has substantial implications for funding, in that we must recognize that our commitment to these veterans will be continuous and that their condition cannot be completely treated by one episode of care. If a veteran is diagnosed as suffering from PTSD, then he or she is also very likely to also be suffering from at least one other psychiatric disorder. The most common co-existing diagnosis observed was alcoholism. Additional findings from this study were that 11.2% of Vietnam theater veterans have current alcohol dependence problems and that 22% of all Vietnam theater veterans with PTSD report current alcohol dependence problems. Implications of this for treatment are very significant, in that many veterans with PTSD require substance abuse treatment and that substance abuse treatment centers are treating veterans for substance abuse who have major co-diagnosis of PTSD and require specific treatment for that. Our treatment programs must be organized in such a way as to utilize our current information and to direct resources to providing treatment in a manner that will be the most effective.

In reviewing the information provided by the NVVRS, it was found that of those veterans with PTSD who had received mental health care from any source (61.7%), only one third (20%) had received their care from the VA. Half of those with PTSD currently receiving care are using VA mental health services. Approximately 20% of veterans with PTSD have used VA mental health facilities, at some time upon leaving the military and one half of those receive services within the 12 months prior to the study. In contrast, roughly 10% of all veterans have ever used the VA for any purpose. Clearly the VA has been recognized by veterans with PTSD as a major source of care, if not the main source. This availability of expertise of services must be encouraged and expanded.

It is clear that substantial additional analysis of the NVVRS data is required. The Special Committee has recommended that funding be obtained to carry out additional analyses of NVVRS data on clinical aspects of PTSD and partial PTSD and their implications for utilization of VA clinical resources. They further recommended that such analyses focus on these questions with specific reference to special populations of war-zone veterans, such as women, minorities and handicapped veterans. The special needs of women veterans will require specific attention in the areas of availability of substance abuse treatment, educational enhancement of VA personnel and the need for a coordinator for women veterans at each medical center. Our institutions have largely focused on the needs of male veterans; we must now expand that focus.

It is essential that the PTSD clinical teams be further supported. Current funding permits the existence of 23 such clinical teams around the nation. There is clearly a need for many more, as there is a need for standardization of our inpatient treatment design. The NVVRS has indicated to us vast numbers of underserved groups suffering from PTSD. It can be a benefit to us to look at specific allocation of bed increases or dedication of resources by region. In addition, it is essential that standards for treatment and staffing models be established for these special units. With the 23 newly selected PTSD treatment teams and the 16 specialized treatment units for PTSD and the National Center for PTSD, there are now approximately 45 identified sites providing dedicated PTSD services in the VHSRA. These services, along with the evaluation conducted by the Northeast Program Evaluation Center, will enable VHSRA to develop program guidelines that will maximize resources for veterans suffering from war-zone stress.

Under the auspices of Public Law 98-528, the National Center for PTSD will be the center of PTSD services. The Center will develop program guidelines, facilitate research and educational programs, conduct system-wide evaluations and disseminate new information. It is critical that the National Center for PTSD be adequately funded and that adequate allocations of funds be dedicated for research and education in the area, as well as for clinical care. The goal of a National Center that will provide leadership has, we believe, been reached with establishment of the current center. It is now up to Congress and the Department to establish adequate funding so that the National Center can fulfill its stated mission. To that end, we strongly support Section 204, which addresses funding for PTSD programs. It is essential that we track our resource commitment to the problem and that adequate funding be prioritized to meet the needs of this veteran group.

PTSD is the only psychiatric disorder that almost by definition is, per se, military war-zone stress related illness. The Veterans Administration treats many critical medical conditions that have no relationship to combat or military related service. Research and treatment PTSD needs to be adequately funded to address the strong need indicated by the results of the NVVRS study. However, in this time of severe budgetary constraints for the practitioners in the field, we find it very difficult to provide the essential services within medical centers to deliver care to this special population.

The NVVRS indicates that PTSD is a chronic psychiatric disorder that is associated with significant impairment in psychological, marital, social, and vocational functioning. Such data clearly indicate that the VA is not meeting the clinical needs of Vietnam theater veterans who suffer from the psychiatric sequale of exposure to war-zone stress. New resources must be allocated and old resources reallocated for the unmet need for the treatment of PTSD among this very large number of Vietnam war-zone veterans. Such resources should include VAMC inpatient and outpatient general mental health programs, vet center facilities and special PTSD treatment initiatives such as PTSD treatment teams (PCTs), specialized inpatient unit for PTSD and inpatient dual-diagnosis programs for patients with PTSD and other disorders, such as alcohol/substance abuse.

Mental Illness Research, Education, and Clinical Centers (MIRECCs)
S. 86

The APA and NAVACOP appreciate the opportunity to testify in support of S. 86, legislation introduced by Senator Cranston which would require that the Veterans Administration establish five mental illness research, education, and clinical centers (MIRECC's). It is no secret that the funding level for psychiatric research in the VA is vastly disproportionate to the utilization of psychiatric services, and that the resulting deficiency in resources for psychiatry in the VA only serves to diminish the quality of care provided a population in dire need of the services our profession is equipped to provide. Senator Cranston's willingness to address and alleviate this problem through the introduction of S. 86 indicates that these previously ignored critical issues - quality of care and the importance of research in the VA - have reached crisis proportions which demand your immediate attention and action.

At an April 1985 meeting of the Special Purpose Committee to evaluate the mental health and behavioral sciences research program of the VA and its merit review evaluation process, questions regarding the commitment to mental health and behavioral science research crystallized around a number of topics. The psychiatrists at the meeting from the academic/scientific community and those working within the VA research system, spoke about the need for greater financial support for mental health research career development. While they granted that the track record over time has improved substantially, the key argument was made that proportionally, psychiatric research falls far short of the "burden of psychiatric illness among veterans."

In part, some of this difficulty may be the result of historically insufficient funding for both training and staff positions within the VA for those in psychiatry. With the ever-increasing number of patients with psychiatric illness, few staff or house staff psychiatrists are able to add the conduct of research to their clinical responsibilities.

The data supporting claims that support for psychiatric patients and psychiatric research is under-funded is overwhelming. In 1987, the VA provided 237,000 episodes of hospital care for psychiatric illness to 152,000 veterans. In 1987 and 1988, 50% of all patient visits to outpatient clinics were for mental health-related care needs. It is alarming that a mere 17% of research support monies were directed towards psychiatry in the first half of FY '87. In addition, the dollar amount for behavioral research represents less than 10% of the total budget. The data confirms that, obviously, psychiatric resources are being heavily utilized by veterans. Apparently what has not been evident is the disproportionate share of dollars directed to psychiatry.

Particular psychiatric conditions are over represented in our veteran population. Veteran patients have a high incidence of schizophrenia, substance abuse conditions, post-traumatic stress disorder and geropsychiatric illnesses, such as Alzeimer's Disease. We must provide national leadership for treatment and research of these particular populations who have no where else to turn.

Research is on the threshold of a new understanding of the bases of major mental illnesses. For example, research on Schizophenia — a disease twice as common as Alzheimer's disease — has encompassed a broad spectrum of sciences — from the most molecular of the biological sciences to the broadest of the behavioral. Clues to etiology and treatment are being sought in the biochemistry of nerve cells as well as in the psychology of human personality; in methods for visualizing the brain as well as in techniques for assessing intellectual functions; in the assessment of drug therapies as well as in the evaluation of vocational rehabilitation programs. Treatment costs for the nation for schizophrenia exceed $7 billion annually. Much must be done to alleviate the suffering from schizophrenia. The creation of this legislation is certainly a step in the right direction.

In the area of Alzheimer's disease you should know that as many 2.5 million Americans by the year 2000 will be diagnosed as suffering from this devastating disease. Among the Veterans population alone the anticipated prevalence of Alzheimer's disease and other dementias will rise from over 200,000 veterans to 500,000 veterans. As a nation we spend $40 to $50 billion a year to care for elderly dementia victims, yet in FY '87 we spent less than $80 million on research on all forms of dementia. However, through research we are on the brink of major scientific breakthroughs. Research has led us to the identification and localization of a neurochemical deficit in the brains of patients with Alzheimer's disease. Researchers have identified both a protein and a blood platelet abnormality. Studies such as these may well lead to the development of a positive diagnostic marker for the disease.

In the area of addictive disorders, there is a well publicized national crisis. Substance abuse is a major problem for veterans and the VA delivers a great deal of treatment in this area. The VA is currently conducting or supporting alcoholism research, considered critical and unique to the field. The New England Journal of Medicine recently published the findings of one such project, conducted at the Philadelphia VAMC, in conjuction with the University of Pennsylvania. Researchers concluded that outpatient detoxification is "an effective, safe, and low-cost treatment for patients with mild-to-moderate symptoms of alcohol withdrawal." This is just one example of the major contribution of VA research on the entire health care delivery system.

The VA already has a program of geriatric centers (GRECCs) which has stimulated progress in disorders of the aging population. The proposed MIRECCs can draw on this experience in setting up centers of excellence which would increase the volume of research in the mental health area while not sacrificing quality. Support for Research Training, an important adjunct to basic research support, is critical in order to attract talented professionals to research careers, specifically in evolving specialty areas such as schizophrenia and Alzheimer's disease. Consider this the "infrastructure" of research - the expert manpower needed to promote scientific research of the scale and scope necessary to meet the challenges of mental illness.

Support for the development of talented psychiatric researchers clearly has been disproportionately small compared to the needs of the field. We have argued this repeatedly before the House and Senate Appropriations Committees in our advocacy for research supported by the National Institute of Mental Health (NIMH) and Congress has begun to recognize the need to build an expert cadre of research manpower upon whom the success of the research mission depends. We emphasize to you today that the present supply of research personnel is not nearly equal to the task of carrying out the research initiatives described in my testimony. The inability to recruit and retain psychiatrists in the VA has reached a critical stage.

With the support of the VA Associate Deputy Chief Medical Director, the Mental Health & Behavioral Sciences Service recently conducted a field study in response to concerns over the increasing number of psychiatric physician vacancies and difficulties in the retention of psychiatrists. There are currently 1860.63 total psychiatric physician full-time employee equivalents (FETEEs). The survey of 160 VA Medical Centers documents a 14.59% vacancies, of which 29 are full-time Chief of Psychiatry vacancies, 189 are full-time staff vacancies and 50 are part-time staff vacancies. The total vacancy rate for unaffiliated medical centers is 24%, with 33% having a duration of 1-6 months, 66% with a duration of 7 months or more, and 13.5% have been open for 13 months. The vacancy rate for affiliated VAMCs, usually located in urban settings with smaller psychiatric bed sections, is 11.6%. The vacancy rate for psychiatrists located in centers with large psychiatric bed sections is 16.4%, with eighteen percent of psychiatrist vacancies vacant for six months or more, and 13% of psychiatrist vacancies with a duration of 13 months or more.

Increased attention to psychiatry research funding is essential to stem the tide of psychiatric vacancies within the VA. The problems associated with recruitment and retention would be significantly diminished if a special effort was made to improve the professional milieu in which these physicians work. Establishment of MIRECC's would have a positive impact well beyond the institutions designated to have centers. The reputation of psychiatry within the VA, and the commitment of the VA to mental health and substance abuse issues, would be highlighted by the establishment of such centers.

Mr. Chairman the science of understanding mental illness has helped to eliminate the traditional stigma attached to the disorders I have outlined.

We have discovered that there are biological bases to most of the major debilitating disorders, thereby reducing the historic stigma heretofore felt to be the result of environment, social factor, etc. This is the message that our citizen allies continue to articulate with us before Congress. In fact research support is a leading issue of the families of the seriously mentally ill. Establishing Mental Illness Research, Education and Clinical Centers of Excellence provides an opportunity for the Verterans Administration, and the research community together, to participate in a state-of-the art innovative process. It is a modest investment to make when one considers the monumental possibilities for improving care and treatment of veterans.

Homeless Chronically Mentally Ill (HCMI)
S. 405 and S. 846 (section 3)

The APA and NAVACOP support strongly, S. 405 and Section 3 of S. 846, legislation providing for an extension of the highly successful VA Homeless Chronically Mentally Ill (HCMI) program. The extension of this program for veterans who have service-connected chronic mental illness disabilities and chronically mentally ill veterans who are receiving VA hospital or nursing home care, is essential if we are to address the needs of the homeless.

When you look at the homeless mentally ill, realize that you are dealing with two problems with multiple causes and subgroups: homelessness and chronic mental illnesses. Each, in and of itself, is a formidable challenge to resolve, but combined, they present a problem of unprecendented magnitude and complexity. The population bears the cross of a dual disenfranchisement from society and its agents of service delivery: the mentally ill are often excluded from programs designed to serve the homeless, and those who are homeless are typically screened out from receiving services designed for the chronically mentally ill. The homeless mentally ill have become our society's "untouchables," unable to advocate for themselves, unable to protect themselves from harm, unable to acquire the bare necessities of living.

In our country the number of severely and chronically mentally ill among the homeless is staggering (from 20 to 80 percent of the estimated 750,000 to three million homeless, depending on where the study was done) live in the street or in shelters. Surveys estimate that between 18% and 51% of the homeless population are veterans. The VA's HCMI comprehensive community-based effort, composed of six stages (outreach, intake, psychiatric and medical examinations, initiation of treatment, residential care through contracts with non-VA community providers and intensive case management) is unique, and should serve as a model to policy makers across the country as they deal with this overwhelming crises.

The second annual report of the HCMI program revealed that of the 10,524 veterans assessed in the 43 VA Medical Centers with programs, 83% were either living in shelters or had no residence. Psychiatric diagnoses were recorded for 97.3% of those receiving assessments. Psychiatric examinations diagnosed 55.2% with alcohol abuse or dependency and 18.4% with drug abuse or dependency, 12.3% with schizophrenia, 9.3% with PTSD, and 9.3% with affective disorders. Many of these veterans were diagnosed with a dual diagnosis involving substance abuse and other psychiatric problems.

We applaud Senators Cranston and Murkowski for their efforts to ensure the existence of this critical program. Senator Cranston's bill (S. 405) provides for a three year extension of the program, eliminates the pilot program designation, and expands discretionary authority to include chronically mentally ill veterans with service-connected disabilities rated at 50% or more who were included in the original program. Senator Murkowski's bill (S. 846 section 3) extends the program for five years and eliminates the pilot program designation without expanding eligibility. We commend both efforts to extend the program, understandable we prefer a five years extension, and, support program expansion for chronically mentally ill veterans with service-connected disabilities rated at 50% or more.

Compensated Work Therapy (CWT)
S. 846 and S. 13 (amendment 124)

For the homeless poplulation, a simple, single housing facility is insufficient. Instead, these disabled citizens require a range of graded, step-wise housing opportunities from large halfway houses to smaller group homes, to individual apartments or homes. As opposed to those out of work, burned out of their homes, ect., the severely and chronically mentally ill cannot resume their full personal, familial, social, vocational and community lives following treatment of their actue phase of illness. They must also slowly recuperate from their illnesses — often progressing from acute inpatient units to chronic state hospitals to rehabilitation programs to day hospitals or half-way houses to group or foster home to independent living — in a slow but progressive manner. Thus, they need a range of housing opportunities, that includes more "restrictive" and larger sized facilities, smaller group and family homes, and eventually, individual homes or apartments.

Mr. Chairman, in 1955 there were 559,000 patients in state hospitals; today, at any given time, there are approximately 123,000. Conceptually, deinstitutionalization was not flawed; its implementation was. The importance of psychoactive medication and a stable source of financial support was perceived, but the importance of developing such fundamental resources as supportive living arrangements was not clearly seen nor implemented. Nor was it foreseen how reluctant many states would be to allocate funds for community-based services. Almost immediately after deinstitutionalization occurred, society reacted vehemently to the presence of the homeless on our cities' streets.

Now the VA is experiencing its own form of deinstitutionalzation. Since the implementation of the Resource Allocation Methodology (RAM) — the VA equivalent of hospital DRGs (Diagnosis Related Groups) which Medicare did not apply to psychiatric hospitals or psychiatric units of general hospitals because the research data did not support psychiatric DRGs — VA Psychiatry has experienced a 21% increase in episodes of care, and a 13% increase in the number of unique individuals treated. By 1987, the percentage of discharges for individuals suffering dual-diagnosis conditions involving a serious psychiatric disorder and an alcohol or substance abuse disorder exceeded 74%. The RAM model provides incentives for markedly shortening the length of stay, creating a "revolving door" treatment plan for patients with severe psychiatric illnesses. We need programs such as CWT to help address the financial implications of RAM — which have forced shorter lengths of stay and therefore, increased episodes of care — and to help stabilize patients in a less expensive and less intense alternative setting.

The VA's compensated work therapy program, established to provide vocational skills to veterans so that they can achieve independent living status, serves as one piece of a continuum of care to homeless veterans. At the current 43 cites, the VA contracts with community businesses, industry or nonprofit corporations to provide work opportunities for veteran patients. The 6,581 veterans are learning marketable skills that will eventually permit them to work in a nonsheltered environment.

We believe that homeless veterans would benefit substantially from the development of a new program of therapeutic housing on a transitional basis, which would be coordinated with the current CWT program. Senator Cranston's amendment 124 to his bill, S. 13, provides the VA the opportunity to expand CWT by permitting the Department to implement a five year pilot program to contract with nonprofit corporations to run CWT programs which encompass a therapeautic residence. In order to facilitate the relationship, the VA would be permitted to make an interest-free loan, repayable within five years, to the nonprofit corporation, in the amount of either 25% of the purchase price for the therapeautic residence or the total of the first year's rent. We feel such a pilot program would work in many settings across the country. The program design utilizes community resources, private-sector talent and VA expertise. However, we also believe that Senator Muckowski's bill (S. 846) provides even greater flexibility in its design.

Senator Murkowski's bill (S. 846) would authorize the VA to purchase, lease or otherwise acquire houses to be used as therapeutic transitional housing for veteran patients participating in the CWT program. Mr. Murkowski's bill provides great flexibility to the VA; permiting community involvement, essential to the success of such a program, allowing for utilization of residential properties acquired as a result of a foreclosed home loans which may require repair work by CWT participants, and allowing for contracts to be made with nonprofit corporations.

A pilot program designed with flexibility enhances the VA's ability to impart to homeless veterans, an adequate number of rehabilitative services providing socialization experiences, training in the skills of everyday living, and social rehabilitation, specifically directed to the needs and resources of any given community. Major metropolitan cities across the country have varying degrees of need, dollars, and facilities. Being able to provide financial incentive could mean the difference in having or not having a program. Rurals areas provide even more unique financial considerations. Given the demonstrated need for facilities for homeless veterans, the economic pressures upon states, cities and municipalities, and the legislative goal to develop a pilot program for evaluation purposes, we encourage the Committee to develop as broad a pilot program as possible.

TESTIMONY OF

KENNETH A. KLAUCK, PH.D.

Chief of Psychology Service
Clement J. Zablocki VA Medical Center
Milwaukee, Wisconsin

on behalf of

THE AMERICAN PSYCHOLOGICAL ASSOCIATION

AND

THE ASSOCIATION OF VA CHIEF PSYCHOLOGISTS

before the

UNITED STATES SENATE VETERANS' AFFAIRS COMMITTEE

June 14, 1989

Good Morning. Mr. Chairman, I am Kenneth A. Klauck, Chief of Psychology Service at the Clement J. Zablocki VA Medical Center in Milwaukee, WI. I am testifying, today, on behalf of the 90,000 members of the American Psychological Association (APA) and the Association of VA Chief Psychologists (AVACP), of which I am the President.

APA is the major scientific and professional society representing psychology in the United States. Many of our members are researchers and practitioners in the Department of Veterans Affairs' (VA) regional centers and hospitals across the country. Within the Veterans Health Service and Research Administration there are 1587 psychologists who are trained as practitioners/ scientists and employed full-time. In addition, 175 psychologists work part-time. The Association of VA Chief Psychologists represents 130 Chiefs and 50 Assistant Chiefs of Psychology Service with the Veterans Health Service and Research Administration.

Thank you for inviting us to testify on legislative initiatives under consideration by the Committee to create mental illness research, education and clinical centers (MIRECCs), and to enhance programs for veterans suffering from post traumatic stress disorder (PTSD), to extend the homeless chronically mentally ill (HCMI) program, and to expand compensated work therapy (CWT) with a therapeutic residence program. We strongly support the efforts of the Committee to assist our nation's veterans during these tight budgetary times.

Provisions in S.13 that allow for the expansion of research on PTSD, and the treatment of combat veterans suffering from this disorder are timely reminders of the work that is yet to be done in the VA. Psychological research has shown how devastating PTSD can be for Vietnam veterans as well as combat veterans from World War II and Korea. PTSD is a psychological disorder that is in the most basic sense "service-connected".

Section 201 of S.13 insures that the VA will offer treatment to veterans regardless of whether there has been a finding of service connection. This policy waiver will make it possible for veterans who are experiencing PTSD-like symptoms to access the VA's health care system. As evidenced by the findings of the Research Triangle Institute (RTI) report, 829,000 veterans have diagnosed cases of PTSD or symptoms associated with the disorder. Psychological interventions have been effective in treating this chronic condition and we believe this section will assist in addressing the scope of the problem.

Mandates in section 202 that would require the VA's Special Committee on PTSD to evaluate research that has already been done and monitor current activities within the VA will facilitate communication between Congress and the Secretary. In addition, standardized reporting will further emphasize that PTSD is a priority for the VA. Similarly, good psychological research will strengthen the findings reported in the RTI study by reassessing the incidence of PTSD (as mandated in section 203) among Asian-Americans, American Indians, native Hawaiians and other native American Pacific Islanders, and Alaskan Natives. We are supportive of section 204 which calls for the prioritizing of funding activities within the VA for PTSD and other areas.

The establishment of up to five mental illness research, education, and clinical centers (MIRECCs) within the VA as envisioned in S. 86 would be an important addition to current VA research programs that are already recognized for their excellence. I was encouraged to note that Senator Cranston's bill would allow for the coordination of research, the training of health care personnel, and the development of improved models of clinical services for eligible veterans. VA psychologists have long been active and are leaders in research design and methodology in the VA, other health systems, and in academic and research centers throughout the world. Research, clinical services, and education is certainly a winning combination.

Psychological research in the VA had a small beginning when a clinical psychology section was organized within Psychiatry and Neurology Services in 1946. A greater emphasis on clinical services beginning in the 1970's led to fewer career positions for research psychologists. MIRECCs can offer the proportional monetary support to research that's in line with the need. VA psychologists agree that research is an investment in the present and future health of our veterans. Without a doubt, it improves care. Also, not to skirt the issue of budgetary considerations, research funding is cost effective. In fact, a relatively small investment can serve to facilitate the development and utilization of behavioral techniques that will, in the long run, save money in non-mental health care utilization.

I am particularly pleased with this proposal because MIRECCs are modeled after the very successful Geriatric Research, Education, and Clinical Centers (GRECCs). GRECCs have been extremely effective, most importantly, because of their multidisciplinary approach to program administration, funding, research, and implementation. Partnerships with graduate schools of psychology, medical schools, nursing, social work, and other allied groups will allow for maximum exposure and assimilation of the broad range of expertise within the various mental health disciplines.

I commend Senator Cranston and the committee for their support of the MIRECC program. Depression, AIDs, PTSD, alcoholism and substance abuse, and a host of other disorders are serious national problems that affect veterans, and present a challenge to VA researchers and health care practitioners.

As I commented earlier in my testimony, we are supportive of the provision in S. 13 that calls for a study of the prevalence of PTSD in Asian-Americans, American-Indians, Native Hawaiians, other Native-American Pacific Islanders and Alaskan Natives. Likewise, we support Senator Matsunaga's bill, S. 192, that requires a broader study of psychological problems of Vietnam veterans in the above mentioned populations.

For the last few years, the VA has dealt with chronically mentally ill, homeless veterans by utilizing a new approach. The Homeless Chronically Mentally Ill (HCMI) Program, begun in 1987, has served thousands of homeless veterans through a program of community outreach, health care service and residential treatment. This program responds to a significant need. According to studies on the homeless, between 18% and 51% of the total homeless population is made up of veterans, many of whom served in Vietnam. Assessments of individuals for psychological and medical problems, outpatient treatment, residential treatment outside the VA and case management are being accomplished with the assistance of dedicated outreach workers. The HCMI program's track record has been excellent and we strongly support S.405 which authorizes permanent program status. The homeless problem can only be solved by a long-term commitment and the HCMI program can clearly offer that to veterans. Its presence in 26 states reflects the ambitious nature of the program.

Lastly, I'd like to take the opportunity to comment on proposals that would make changes in the compensated work therapy (CWT) program. In doing so, I'd first like to acknowledge Senator Cranston's efforts over the last several years to see that this dynamic program makes it possible for so many veterans to acquire meaningful job skills - subsequently, returning them to the community as fully functioning taxpaying members. On behalf of AVACP and the APA we appreciate your efforts in this regard.

Psychologists in the VA have a long history of providing comprehensive vocational rehabilitation assessments and program support within VA medical centers in cooperation with our veterans benefits colleagues and rehabilitation services. CWT is a valuable tool in the treatment of mentally ill veterans and we would certainly like to see expanded opportunities for training as well as the addition of therapeutic housing. Transitional housing of this type allows for inexpensive living arrangements in addition to an expansion of the rehabilitation program beyond the work environment.

AVACP and APA were encouraged to note the introduction of Senator Murkowski's bill to modify and expand the CWT program and indicated support in letters to the Senator last month. We believe it offers the kind of flexibility that will well serve the CWT program and the veterans it assists. It also removes some roadblocks that have in many respects limited the potential of the program. One such improvement involves the authority for the VA to contract with any source, government or VA. Another allows funds in the Special Therapeutic and Rehabilitation Activities Fund (STRAF) account to be used for administration of the CWT program.

Providing therapeutic residences (TR) would be, as mentioned a great benefit to the success of the CWT program. I was also glad to see that the VA must work with the community to ensure acceptance of the TRs and therefore, the ultimate success of this program. In addition, the establishment of non-profit corporations to provide a funding mechanism above and beyond any government contributions is a complement to the VA's expanded CWT mission.

Senator Cranston's draft amendment to S.13 is a unique approach to this program. It's obvious that a substantial amount of work went into its development. As mental health providers, our primary concern lies with patient care. We are particularly pleased with the section within the amendment to allow for the provision of in-kind services (i.e., clinical) to the non-profit corporations. VA facilities would benefit greatly if services to the program were considered as "pass through" expenses not subject to the VA's Resources Allocation Methodology (RAM). We also support an amendment to permit contractual arrangements between the CWT and the VA or other government entities as well as the use of CWT funds for educational travel.

We are somewhat concerned with the time that it may take to establish sites for this project in light of the requirement that non-profits must run both the therapeutic residence and the CWT. We have all been impressed with the program in Menlo Park, California. However, a model of this type may not be applicable to other sites across the country. We might suggest a dual model that would remove some of the burden on the non-profits by allowing the VA to continue to run the CWT and coordinate their efforts with non-profits willing to manage the therapeutic residences. In any event, we pledge our assistance to the Committee as you endeavor to formulate a workable model.

Thank you for the opportunity to testify today. I'd be glad to answer any questions you might have.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SENATE COMMITTEE ON VETERANS AFFAIRS
June 14, 1989

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the more than 1.2 million members of the Disabled American Veterans and its Ladies' Auxiliary, may I say that we sincerely appreciate the opportunity to appear here today to present our views on various legislation regarding the Department of Veterans Affairs' (VA) health care system and the provision of mental health services.

Mr. Chairman, your letter of invitation requested our views on Sections 201 through 204, 221 and your amendment to Section 212 of Title II of S. 13,; S. 86; S. 192; S. 405; and S. 846, the "Veterans Compensated Work Therapy Program Improvements Act of 1989."

Title II of S. 13

Mr. Chairman, Section 201 of S. 13, the "Veterans Benefits and Health Care Act of 1989," proposes appropriate amendment to Section 602 of Title 38, USC, directing the VA to furnish medical care, on a priority basis, to any veteran who served in a combat area and is subsequently diagnosed as suffering from combat-related Post Traumatic Stress Disorder (PTSD).

As we understand this provision, a mental health professional, designated by the Chief Medical Director (CMD), must diagnose PTSD and conclude the condition is related to the veteran's military service. Then, the VA would be required to furnish needed hospital and/or outpatient services for that condition.

Mr. Chairman, we are mindful and appreciative of the logic and rationale that prompted the introduction of this measure.

Although we are supportive of the intent of Section 201, there are two concerns we would wish to see addressed prior to our full support being given.

The first concerns the concept of priority treatment being furnished to veterans seeking care for PTSD. We agree with current statutory language and procedures attaching a priority system of treatment to defined groups or classes of veterans, i.e., treatment of a service-connected disabled veteran for the service-connected disability.

However, to attach a priority for care based simply on diagnosis and not need, or to place a priority of care simply on the basis of diagnosis alone, may not always represent sound medical practice or, in fact, equity to access of care.

Therefore, we suggest that the concept of providing care on a priority basis based solely on diagnosis be abandoned.

Secondly, we remain constantly vigilant concerning the integrity of the VA benefit delivery system of which health care compromises a significant component.

Mr. Chairman, in an era of severe budgetary shortfalls and restricted access to VA health care to those veterans mandated care -- so-called "Category A" veterans -- the prospect of expanding eligibility to a certain group of veterans who are not, adhering to strict definition, service-connected disabled veterans engenders a great deal of concern and apprehension.

Concurrent with our concern in this regard is the realization that a great many veterans diagnosed as afflicted with PTSD are so diagnosed as a result of combat-related causes.

Mr. Chairman, there exists a continuing controversy surrounding the issue of securing service-connected disability compensation for PTSD and the potential impact that process may have on the successful outcome of the treatment regime. Clearly, this is not an issue that will be resolved in the short-term, or perhaps ever.

Being mindful of the need to preserve program integrity while ensuring that veterans with disabilities clearly related to their military service receive appropriate services from the VA, we suggest further amendment be considered to this measure.

Specifically, we suggest a "Memoranda Rating" be accomplished for those veterans who would potentially fall into the category envisioned by Section 201. By so doing, the integrity of the program is preserved and the veteran remains, for all practical purposes, removed from the formal adjudicative process.

Mr. Chairman, we believe this procedure can be effectively performed in an expeditious manner and will ensure that those veterans requiring treatment for combat-related conditions or conditions otherwise directly related to honorable military service, will receive appropriate medical care.

Section 202 would require the Special Committee on PTSD to submit three additional reports to the Secretary and, concurrently, to the Veterans Affairs Committees.

The first report would require the Special Committee to set forth their evaluation of the results of the recently completed

Research Triangle Institute (RTI) study -- as mandated by Section 102 of Public Law 98-160.

Mr. Chairman, the Special Committee's report would include:

- an overall evaluation of the conduct, validity, and meaning of the study;
- an assessment of the VA's ability to meet the variety of psychological needs of veterans afflicted with PTSD in readjusting to civilian life;
- an evaluation of the Secretary's report of the RTI study; and
- recommendations for additional research.

Additionally, the Special Committee would be required to submit two additional reports -- not later than February 1st of 1991 and 1992 -- updating information contained in the original report.

Mr. Chairman, the DAV has no official position regarding Section 202. However, if it is the consensus that such reports are necessary and would yield additional beneficial data, we would not object to its favorable consideration.

Section 203 proposes a study of the prevalence and incidence of PTSD among Asian-Americans, American-Indian, Native Hawaiians, other Native American Pacific Islanders and Alaska Native Vietnam veterans with particular attention devoted to women veterans and veterans with service-connected disabilities.

As you know, Mr. Chairman, the RTI study over-sampled the racial/ethnic groups of Blacks and Hispanics, but did not over-sample the groups contemplated in this measure.

One concern regarding this measure is the availability of a group of veterans large enough to be studied and deemed statistically significant on which to base results and draw any firm conclusions.

With that concern noted, we would not object to the favorable consideration of this measure.

Section 204 would direct the Secretary, in conjunction with annual budget submissions to Congress, to identify the amount of appropriations estimated to be obligated for PTSD activities, to include:

- payment of compensation;
- treatment of veterans afflicted with PTSD;
- education, training and research; and
- the operation of the National Center on Post Traumatic Stress Disorder.

Mr. Chairman, as we envision the intent of this measure, it is designed to ensure, to the greatest extent possible, that the VA is allocating sufficient resources to meet the needs -- present and anticipated -- of veterans with PTSD and related programs.

It would seem appropriate at this juncture to reiterate to the Committee that we not only support, but actively advocate, a similar approach in the entire budget formulation methodology utilized by VA.

As you will recall, Mr. Chairman, the veterans' service organizations, in the Independent Budget, recommends a similar approach be used by the VA as a necessary prerequisite for responsible budget formulation.

Specifically, we recommend that Congress direct the VA to establish specific goals in its budget justification that represents the level of services to veterans and their families that are expected to be provided with the appropriations requested. (Pages 23 - 24 "The Need is Now, an Independent Budget by Veterans for Veterans Programs, Fiscal Year 1990.")

Mr. Chairman, there appears to be a crying need for a revision of the entire VA budget formulation methodology. Therefore, the DAV suggests that the principle embodied in Section 204 be expanded to include not a single entity, but the entire broad range of issues and services involved in the Department's budget formulation process.

Finally, Mr. Chairman, with respect to S. 13, Section 221(a) proposes to transfer responsibility for the management and direction of VA Security Services from the Chief Medical Director to the Assistant Secretary assigned responsibility for management, productivity and logistics support functions within the Department.

Additionally, Section 221(b) would require VA to provide a report to Congress containing:

1. plans for improving the training, recruitment and pay of VA security and law enforcement personnel; and
2. an assessment of the need for establishing a policy on the issuance of weapons to such personnel assigned to high crime areas and the advisability of reducing VA police services in certain areas while increasing services at facilities with more significant security problems.

Mr. Chairman, Section 221(a) is a management issue involving some obvious advantages and disadvantages, which we defer to the VA and this Committee to resolve. We have no objection to the provisions of Section 221(b).

S. 86

Introduced by yourself, Mr. Chairman, this measure proposes adding a new subsection -- (g) -- to Section 4104, Title 38, USC, directing the Secretary to designate not more than five (5) VA health care facilities as Mental Illness Research, Education and Clinical Centers (MIRECCs).

The stated purpose of S. 86 is to improve and expand the VA's capabilities to provide the most appropriate and effective treatment to veterans suffering psychiatric illness, especially as it relates to their military service; to advance scientific knowledge regarding mental illness through a program of research; and develop improved methods of treatment, as well as provide training activities for health care professionals involved in the treatment of psychiatric illness.

Mr. Chairman, several years ago, a decision was made by the VA that psychiatric inpatient care would be considered acute care and thus be subject to the Diagnostic Related Groups (DRGs) based Resource Allocation Methodology (RAM). This was implemented despite serious concerns that psychiatric care could not be accurately estimated in this manner.

Since that time, a variety of serious, negative consequences have ensued by utilizing the DRG methodology. Veterans' lengths of stay cannot be accurate predicted, nor can a clear distinction be made between chronic and acute psychiatric illness.

As a result of an inappropriate RAM, as well as other factors, VA psychiatric resources have suffered immensely in years past.

Mr. Chairman, it has been estimated that approximately 40% of all VA bed days are concentrated on veterans suffering from some form and degree of mental illness. Yet, the total dedicated dollars to provide such care or engage in related research is extremely small and disproportionate.

Though the DAV has no official position relating to S. 86, we could be supportive of its favorable consideration by the Committee.

However, as we read this measure, there appears to be language contained therein which we feel requires deletion and/or modification.

Specifically, we refer to paragraphs three and four of the proposed new Subsection (g) of Section 4101, Title 38, USC, regarding the allocation of funds to be used for the establishment of MIRECCs.

Mr. Chairman, the DAV is a strong advocate for a viable research component, especially Rehabilitation Research and Development (RR&D) within the Department.

For many years, we have been concerned with what we view as a somewhat meager and certainly disproportionate funding level for RR&D when compared to basic medical research. While we fully support adequate funding of the VA's medical research program, we are especially supportive of RR&D, as we feel there exists a tremendous potential to meaningfully address and assist in meeting the needs of severely disabled veterans, especially as it relates to combat-incurred disabilities, such as amputations.

This measure's current construction raises a concern that already scarce funds may be withheld from RR&D in order to fund mental illness research.

In our view, specific funds should be appropriated and dedicated expressly for the purpose of meeting the intent of this measure. This position becomes more apparent in view of Section 135, Public Law 100-322, designating mental illness as a specific research mission of the VA.

S. 192

Introduced by Senator Matsunaga and cosponsored by you, Mr. Chairman and Senator Inouye, S. 192 proposes the conduct of a comprehensive study of the psychological problems of certain minority Vietnam veterans.

As S. 192 and Section 203 of S. 13 -- which we have previously discussed -- are virtually identical, we have nothing substantial to add to what we have already stated.

S. 405

Introduced by yourself, Mr. Chairman, this measure is directed toward strengthening the VA's efforts and capabilities of providing medical services to veterans participating in the Homeless Chronically Mentally Ill Program.

The provisions of S. 405 would:

- extend the program for three years, through September 30, 1992;
- make the program permanent; and
- make eligible those service-connected disabled veterans rated 50% or more for participation in the program, as well as chronically mentally ill veterans who are receiving VA hospital or nursing home care.

Mr. Chairman, the Homeless Chronically Mentally Ill Program (HCMI) is only two years old, however, it has, in our view, been one of the VA's success stories in the treatment and rehabilitation of veterans.

Therefore, the DAV supports the continuation of this program as envisioned by this measure.

Section 212 of S. 13

Introduced by yourself, Mr. Chairman, and cosponsored by Senators Matsunaga, DeConcini, Mitchell, Rockefeller, and Graham, this measure seeks to significantly expand and enhance the VA's Compensated Work Therapy (CWT) program to include establishing a pilot program of transitional housing and independent living opportunities for program participants.

Major provisions of this measure include:

* a five-year pilot program requiring the VA to promote and participate in the establishment of nonprofit corporations with which VA would contract to run CWT programs;
* authorize VA to make an interest-free loan -- repayable within five years -- to the nonprofit corporation;
* authorize VA to make advance payments to the nonprofit corporation to run a CWT program;
* authorize VA to provide in-kind services to the nonprofit corporation as part of the VA payment;
* authorize the nonprofit corporation to use VA funds to acquire and operate a transitional housing residences;
* authorize VA to transfer from the General Post Fund to the Special Therapeutic and Rehabilitation Activities Fund (STRAF) for the loan or advance payment to the nonprofit corporation;
* direct the VA to transfer not less than ten properties acquired by VA under the Home Loan Guaranty Program to the Veterans Health Services and Research Administration (VHS&RA) to be leased to the nonprofit corporation for transitional housing residences;
* provide for the structure of the nonprofit corporation to be similar to that of the research nonprofit corporations currently authorized by Title 38; and

- provide that the pilot program may be conducted only at VA medical centers that have existing CWT programs.

S. 846

This measure, introduced by the Ranking Minority Member of this Committee, Senator Murkowski, likewise proposes significant expansion and enhancements of the Compensated Work Therapy program to include establishing transitional housing and independent living opportunities for program participants.

Major provisions of S. 846 include:

- extend the VA's authority for five years, through September 30, 1994, to provide care and treatment in halfway houses for homeless veterans with chronic mental illnesses;
- authorize VA to contract with itself or other government agencies or departments to provide therapeutic work for VA patients;
- authorize VA to establish transitional housing for veterans participating in the Compensated Work Therapy program;
- permit VA to purchase, lease or otherwise acquire houses to be operated by VA as transitional housing for veterans who are participating in CWT programs;
- authorize VA to establish nonprofit corporations to provide a flexible funding mechanism for the conduct of CWT programs; and
- require VA to transfer and authorize the transfer of funds from the Homeless Chronically Mentally Ill Program to the Special Therapeutic and Rehabilitation Activities Fund.

As you are well aware, Mr. Chairman, both your amendment to S. 13 and S. 846 propose significant improvements in the manner in which the VA would be authorized to provide services to participants in the CWT program. We applaud the authors of both measures for their obvious concern and commitment regarding this program and also for the extremely innovative approaches taken to accomplish this goal.

In concept and intent, both measures have the full support of the DAV.

Mr. Chairman, the concept of therapeutic/transitional housing, as proposed, represents an area that the VA has not, heretofore, been intimately involved in. The many and varied complexities involved in establishing such a program from both an administrative and operational standpoint, demand close scrutiny and a great deal of detailed discussion.

The prospect of the VA moving in the direction of transitional housing is exciting and is an exercise the DAV desires to actively participate in. Therefore, we eagerly look forward to being an active player in the dialogue and establishment of the program envisioned by these measures.

Mr. Chairman, based only on our preliminary discussions and thoughts regarding the issue of transitional housing, we believe it important to thoroughly explore, as an initial step, the following points:

* adequate appropriations -- "seed money" to the VA for the purpose of making grants to certain nonprofit entities;

* ensuring that participating nonprofit corporations are only those recognized as exempt from taxation under Section 501(c)(3) of the Internal Revenue Code;

* ensuring that the nonprofit corporations are not involved in direct competition with the private sector or for-profit corporations;

* the question of liability for any legal actions or claims that may potentially arise in the conduct of the proposed program;

* adequate supervision and case management -- "tracking" -- of program participants; and

- the question of individual veteran's liability for properties that may be acquired under the foreclosure process as currently employed by the VA.

Again, Mr. Chairman, we wish to applaud you and Senator Murkowski for the introduction of this most innovative and important legislation, and we anxiously await the opportunity to work with the Committee and the VA to achieve a mutually satisfactory and workable transition housing program.

Mr. Chairman, this concludes my testimony and I would be pleased to respond to any questions you may have.

Statement of

The American Legion

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by

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THE AMERICAN LEGION

and

RICHARD S. CHRISTIAN, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION

before the

COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE

MENTAL HEALTH-RELATED LEGISLATION

JUNE 14, 1989

STATEMENT OF RICHARD S. CHRISTIAN, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE COMMITTEE ON VETERANS AFFAIRS
UNITED STATES SENATE
JUNE 14, 1989

Mr. Chairman and Members of the Committee:

The American Legion appreciates this opportunity to provide its views on several proposals relating to veterans health care services scheduled for review at today's hearing.

With respect to S. 13, Title II-Part A, the issue of the care and treatment of veterans suffering from Post-Traumatic Stress Disorder (PTSD) is one that is of longstanding concern to The American Legion. We are pleased to be able to offer comment on this subject.

Section 201 of S. 13 would amend section 602 of title 38, United States Code, to require the VA to furnish needed inpatient and outpatient mental health services to a veteran who served in theater combat operations in World War I, World War II, the Korean Conflict or Vietnam War, or in any area in which hostilities occurred and who has been diagnosed by a VA mental health professional as suffering from service related Post-Traumatic Stress Disorder. Under this provision such care and services shall be furnished for the person's PTSD on a prima facie basis, even though the disorder has not been determined to be service-connected for the purpose of disability compensation.

Mr. Chairman, The American Legion has previously appeared before this Committee and other Congressional Committees in support of legislative efforts to expand and improve the Department of Veterans Affairs programs of treatment for veterans suffering from Post-Traumatic Stress Disorder. As highlighted by the recent findings of both The American Legion/Columbia University Study and VA's study conducted by the Research Triangle Institute (RTI), PTSD affects a significant number of Vietnam combat veterans. It is clear that this disorder is also prevalent among combat veterans of prior wars as well as veterans who have served in areas where active hostilities were occurring. Eligibility for both inpatient and outpatient treatment, including readjustment counseling, has been restricted by current statute. We strongly believe that certain changes need to be made in the law to improve access to needed treatment programs by veterans who have been diagnosed as suffering from PTSD. In particular, we support the provision to require VA to furnish necessary priority care for combat-related PTSD on a prima facie basis, without the need for formal adjudicative action by the Veterans Benefits Administration.

A veteran today, suffering from PTSD, is not entitled to care unless he or she is service-connected or has income sufficiently low enough to be in eligibility Category A. With the budgetary shortfall reported throughout the VA medical care system, veterans' PTSD conditions may be severe enough to require care which a Vet Center is not prepared to provide. Thus, there is a very distinct possibility that veterans suffering from PTSD could be turned away from receiving care due to means test criteria.

Section 202 of this measure would require the Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder to submit an additional three reports to the Secretary of Veterans Affairs and concurrently the Congressional Committees on Veterans Affairs. These would be in follow-up to the five reports originally mandated by Public Law 98-528. The first report, which was due on June 1, 1989, would be concerned with an evaluation of the RTI study findings and VA's capabilities to diagnose and treat veterans with PTSD. The purpose of the second and third reports, due by February 1 of 1991 and 1992 respectively, would be to provide information updating prior reviews of the Department's overall efforts to meet the needs of veterans suffering from PTSD.

Mr. Chairman, The American Legion has been a staunch advocate of the role played by the Special Committee on Post-Traumatic Stress Disorder. The reports of this Committee to the Veterans Affairs Committees are essential in monitoring the Department's efforts to develop appropriate and effective outreach and treatment programs for veterans suffering from PTSD. We have been concerned by the Department's inability to release past reports in a timely manner. The fifth and final report of the Committee, as originally required under Public Law 98-528, was due to Congress on February 1 of this year. According to VA, it is not scheduled for release for several more months.

We are supportive of the proposed requirement for additional reports by the Special Advisory Committee over the next three years. With the increased recognition of PTSD as a major mental health problem among all combat veterans, not just those of the Vietnam War, the Committee's reports to Congress are increasingly important in ensuring adequate resources for the Department of Veterans Affairs are available to meet the care and treatment needs of these veterans. The Committee's reports should be delivered by the Secretary of Veterans Affairs to the Congress within the mandated timeframes and not be subject to the same pattern of delays as have occurred with the previous reports.

Section 203 of this measure would require VA to conduct a comprehensive scientifically valid study, either in-house or by contract, on the incidence of PTSD among Asian-American, American Indian, native Hawaiian, and other native American Pacific Islander - including American Samoan native - and Alaskan native Vietnam veterans, and to submit a report on the results of the study to the two Veterans Affairs Committees by

October 1, 1991.

The final report by the Research Triangle Institute (RTI), released in December 1988, reveals that many Vietnam veterans are afflicted with PTSD symptoms. The RTI study included limited sampling of certain racial/ethnic groups of Vietnam veterans and as a result were unable to develop estimates as to the prevalence of PTSD and other post-war psychological problems of readjustment to civilian life of such groups of Vietnam veterans. The proposed study will, therefore, be directed toward these targeted groups.

Based upon the incomplete understanding of the scope of PTSD in such populations, the culturally based reluctance among veterans from some of these groups to seek treatment, and the reported higher percentage of PTSD already found to exist in certain racial/ethnic groups, we believe it is important to conduct this study, and to provide enhanced outreach services to these veterans, if required.

Section 204 of this measure would require VA when submitting its annual budget document to the Congress (pursuant to section 1105 of title 31, United States Code), beginning with Fiscal Year 1991, to identify the amounts to be obligated in the appropriations requests for: (1) payment of compensation to veterans for disabilities resulting from service-connected PTSD; (2) the treatment of veterans for PTSD related to their active-duty service, including specific designation of funds for inpatient care - specialized programs, general programs, and treatment teams - outpatient care, Vet Centers, and contract care; (3) PTSD education, training, and research (at the National Center for PTSD, at any mental illness, research, education, and clinical centers that may be established); and, (4) for the operations of the National Center for PTSD.

The American Legion has an explicit mandate on this issue set forth in Resolution

No. 10, adopted by the National Executive Committee during its May 1989 meeting. The resolution urges the Congress and the Administration to provide adequate funding for the continued operation of the PTSD inpatient treatment program amd for the badly needed expansion of the program.

Mr. Chairman, we believe the enactment of this provision will help VA to better meet the needs of veterans suffering with PTSD.

Amendment 124 to S. 13 proposes several amendments to section 618 of title 38, United States Code, to improve VA's Compensated Work Therapy (CWT) Program by expanding the authorized sources for the provision of therapeutic work for homeless, chronically mentally ill, and other veterans.

This measure would permit the VA to enter into a contract or other arrangement with any appropriate source, including VA itself or any other Federal entity.

It would also expand the use of VA's revolving fund known as the "Special Therapeutic and Rehabilitation Activities Fund", to train employees in the administration of services under subsection 618(B)(1), as amended.

Amendment 124 to S. 13 proposes to amend section 618 of title 38, United States Code. A 5-year pilot program would be established to create nonprofit corporations with which it would contract to conduct CWT programs, arranged under contracts with private businesses, and to which it could make loans to facilitate the corporation setting up therapeutic residences providing relatively independent group-living arrangements. This pilot program would provide for up to 25 participating sites, to be located at VA medical centers which have existing CWT programs.

There are two bills under consideration at today's hearing which propose to expand and enhance VA's CWT Program, with special reference to homeless, chronically mentally ill veterans.

Mr. Chairman, The American Legion supports the intent of both of these bills and we believe all veterans enrolled in CWT programs will benefit through specific provisions of each bill. We further believe that S. 846, which is discussed later in our statement, will provide the most effective program model to evaluate the objectives of these bills.

To propose that one program model can sufficiently evaluate the objectives of the pilot program fails to take into consideration differing levels of community resource support. While Amendment 124 to S. 13 proposes only a nonprofit corporation program model, three different versions of the pilot program are recommended in S. 846. The program model which may work well in a highly urbanized location may not work as well in more rural locations. Having the flexibility of conducting pilot programs using nonprofit corporations, inhouse VA facilities or private housing will allow a combination of program models to be studied, and provide greater adaptability for specific geographic locations, in our view.

Section 221(A) of this bill would amend section 218 of title 38, United States Code, by requiring that the Assistant Secretary of Veterans Affairs be responsible for the technical and functional supervision - but not the day-to-day supervision or line management - of Security Services at VA medical facilities; and section 221(B) requires VA, within 90 days after enactment of this legislation, to submit a report containing (1) a plan to upgrade its security police training, recruitment, and salaries, and (2) conduct an evaluation of the need for (A) establishing a policy on weapons for VAMCs in high-crime areas, and (B) reducing VA security police services in certain VA facilities with no significant security problems in order to expand such services in centers with greater problems.

Mr. Chairman, for many years The American Legion has been keenly interested in the problems that continue to plague VA Security Service in the form of excessive turnover rates of personnel, ongoing recruitment and retention problems, and a host of other serious shortcomings that demand attention. Our expectation is that VA medical centers will provide a safe environment for the provision of medical care to veterans. Recent reports by the media alluding to negligent VA security officer hiring practices raise serious questions about the adequacy of medical center security and the ability of the VA to hire qualified security officers.

We are pleased that VA is addressing these issues and has reinforced its hiring practices through broadening the initial background investigation of all security officer candidates. Also we are pleased that in some selected medical centers security officers have been approved special salary rates, and in certain instances have been reclassified to the GS-6 level.

Greater oversight continues to be necessary to ensure that VA Security Service does not reach a level of complacency, and that it carries out its responsibility of providing protection to the patients, staff, and Federal property.

Mr. Chairman, with respect to assigning organizational and function responsibility for VA law enforcement and security services to an Assistant Secretary of Veterans Affairs, The American Legion has no formal position. In view of the many problems affecting security at VA facilities across the country, we do believe the administrative, fiscal and personnel needs of the Security Service should be accorded a very high priority by the management of the Veterans Health Service and Research Administration.

We welcome the provision which will require the Secretary of Veterans Affairs to report within 90 days after enactment of this legislation, on a plan to upgrade VA police officer training, recruitment and salaries. However, The American Legion has consistently been opposed to the idea of VA security officers being issued weapons in the course of their duties. There have, unfortunately, been occasions in the past several years of theft, vandalism, and assaults. There have also been cases where VA security officers have been slain in the line of duty. We believe, however, that the proper response to these incidents lies more in the area of improving security officer training, which has been sorely lacking in past years, and in the use of proper equipment such as bulletproof vests.

We also believe the answer to improving security at medical centers in urban, high crime areas can be addressed both through improving officer training and increasing security staff where needed. Often rural, low crime area VA medical centers have barely enough security staff to effectively provide security coverage around-the-clock. The shift of resources and FTEE from rural to urban medical centers would leave these facilities dangerously at risk and would only serve to create new problems.

Appropriate system wide staffing standards need to be developed and adhered to if urban medical centers hope to have sufficient security officer coverage. Reducing the high vacancy and officer turnover rates, by improving pay and benefits, would add to the personnel resources already authorized in urban medical centers.

S. 86 proposes to amend title 38, United States Code, to improve the capability of VA health care facilities to provide the most effective and appropriate services possible to veterans suffering from mental illness, especially conditions which are service related, through the designation of up to five medical facilities as centers of mental illness research, education, and clinical activities and for other purposes (MIRECCs).

Section 1 of this bill would amend section 4101 of title 38, United States Code, to delineate the functions of the new MIRECCs and the conditions under which they are to be established.

Section 2 of this measure will require VA to submit to the Committees on Veterans Affairs annual reports not later than February 1 of 1991 through 1993, on the experience of the MIRECCs during the prior fiscal year, including descriptions of activities carried out at each center, advances made in research, education and training, clinical activities, and efforts used to disseminate useful information produced by such activities.

The Secretary shall also be required to evaluate the effectiveness of the centers in fulfilling the purposes set forth in section 4101 of the title.

The American Legion is supportive of this effort to increase the amount of VA research funding directed toward mental illness, and an increase in education funds and training stipends for academically oriented medical facilities. Additionally, this bill holds promise in reversing VA's inability to recruit well-qualified psychiatrists and mental health professionals by focusing on both research and patient care oriented programs. It should also assist in improving the training of mental health clinicians. Data produced through the proposed MIRECCs could be useful throughout the VA medical care system for the treatment of a myriad of mental disorders.

We note this bill would require at least one MIRECC to be established by July 1, 1990, and would authorize the appropriation of $3.125 million in fiscal year 1990 and $6.25 million each for the next three years. As with the success VA has had with its Geriatric Research, Education and Clinical Centers (GRECCs), we believe the MIRECC proposal will help to allay increasing frustrations within the VA Psychiatry Service over decreasing resources including a disproportionate share of research funding, and help to better understand and treat a variety of mental disorders.

S. 192 would require the Secretary of Veterans Affairs to provide for the conduct of a comprehensive study of the psychological problems of native Americans who are

Vietnam veterans.

The proposed study would focus on the prevalence and incidence of Post-Traumatic Stress Disorder, and other psychological problems experienced by such veterans in readjusting to civilian life in the populations of Asian-American, American-Indian, Native-Hawaiian, other Native-American Pacific Islander (including American Samoan Native), and Alaska Native Vietnam veterans.

Particular attention would be paid to veterans who have service-connected disabilities and to women veterans.

The Secretary would submit to the Committees on Veterans Affairs a report containing the results of the study not later than October 1, 1991.

Mr. Chairman, the intent of this bill is similar to section 203 of S. 13. As stated in our comments to that particular measure, we support the proposed study and believe it will add to the overall understanding of PTSD and how it has affected the psychological readjustment of such targeted veteran populations.

S. 405 would amend title 38, United States Code, to add new section 620(C) requiring the Department of Veterans Affairs to conduct a program providing community-based residential treatment for homeless, chronically mentally ill veterans and to authorize the inclusion of certain other chronically mentally ill veterans in such program.

Under this program, VA will furnish care, treatment and rehabilitative services (directly or by contract) in halfway houses, therapeutic communities, psychiatric residential treatment centers, and other community-based treatment facilities to homeless veterans suffering from chronic mental illness disabilities who are eligible for care under section 610(A)(1) of title 38, United States Code.

It would also provide such care and treatment and rehabilitative services (A) to veterans with service-connected, chronic mental illness disabilities; (B) certain Vietnam veterans described in section 612(A)(1)(B) of the title, who have chronic mental illness disabilities; and (C) veterans being furnished hospital or nursing home care by the Secretary for chronic mental illness disabilities.

The program's authority is set to expire on September 30, 1992. The Secretary shall submit not later than February 1, 1992, to the Congressional Committees on Veterans Affairs, a report on the experience of the Department and a recommendation as to whether the program should be continued or not.

This measure further provides that the authority of the Secretary to enter into contracts under this program shall be effective for any fiscal year only to such extent or in such amounts as are provided for in the appropriation Acts.

Mr. Chairman, The American Legion appreciates the concern expressed for the nation's homeless veteran population as exemplified in this bill. The Homeless Chronically Mentally Ill (HCMI) Program was initially established as a pilot program by Public Law 100-6, and has now been extended through FY 1989. Currently, 43 of VA's 172 medical centers have contracts with 184 community-based residential facilities under the HCMI Program. Additionally, 20 VA medical centers are currently operating the Domiciliary Care for Homeless Veterans Program.

S. 405 would provide for a 3-year extension of the program, codify the program in title 38, and remove the designation as a pilot program.

The second annual report by VA detailing the progress of the HCMI pilot program, released in January of this year, indicates that the program has been implemented as planned and is providing outreach, health care, case management and residential treatment services to large numbers of homeless, chronically mentally ill veterans across the country. In the first 11 months of the program, intake assessment of problems and the determination of immediate clinical needs were conducted on 10,524 veterans and 2,125 of them were placed in residential treatment facilities. This evidence suggests the program is effective and is providing necessary humanitarian services as well as improving the health care and residential status of many veterans.

In light of the success of the pilot stage, we believe the HCMI program should be made permanent, under title 38, in order that it may continue the outreach and treatment to many of the nation's homeless, mentally ill veterans.

S. 846 would amend title 38, United States Code, to improve the compensated work therapy and other services and assistance furnished to homeless veterans and other veterans.

Section 3 of this bill would amend section 115(D) of Public Law 100-322, the "Veterans Benefits and Services Act of 1988," to extend the Homeless Chronically Mentally Ill (HCMI) Program for 5 years, through September 30, 1994, codify the program in title 38, and redesignate the program from a pilot initiative to a permanent program.

This proposal is similar in intent to S. 405.

Section 4 of the measure would amend section 618 of title 38, United States Code, to clarify the authorized sources for the provision of therapeutic work by veterans in compensated work therapy (CWT) programs, and to permit VA to contract with itself or other Government agencies or departments to provide therapeutic work for VA patients.

Section 4 would also amend section 618 to authorize payments for CWT services to be credited to the Special Therapeutic and Rehabilitation Activities Fund. It would further authorize the use of the Special Therapeutic and Rehabilitation Activities Fund (STRAF) for the payment of certain administrative expenses.

Mr. Chairman, these provisions are intended to improve and expand the therapeutic and rehabilitative services provided within the current compensated work therapy program. Although these initiatives are principally designed to provide increased support to the Homeless Chronically Mentally Ill Program, in reality, all veterans participating in therapeutic and/or rehabilitative CWT programs will benefit from the enactment of this legislation.

Section 5 of this bill would amend section 618 of title 38, United States Code, to authorize VA to establish and operate therapeutic and rehabilitation activities in transitional housing.

The Secretary of Veterans Affairs would be authorized to use STRAF funds to purchase, lease, or otherwise acquire residential housing and operate each residence as transitional housing solely for veterans under section 618, as amended, who are furnishing services to the Department and for veterans who are furnished therapeutic work. Homeless veterans would have priority in filling residential vacancies in such proposed transitional housing.

Mr. Chairman, the goal of this proposal is to link VA's CWT Program with a new program of therapeutic transitional housing. By assisting veterans in the development of job skills necessary to live independently, this program will enhance the chances of gradual reentry into community life. At the same time, it provides the structured environment required to meet the rehabilitation needs of certain homeless veterans.

The American Legion Department of Pennsylvania has recently inaugurated a program very similar to that as proposed in this bill in conjunction with the Pittsburgh-Highland Drive VAMC. The Department formed a nonprofit corporation, bought four VA foreclosed properties, and made them available to HCMI patients at the Highland Drive VA Medical Center who assisted in the renovation work required on the properties.

These formerly homeless veterans with chronic psychiatric and/or substance abuse problems, would otherwise have no place to live after their hospital discharge. Under the HCMI program, they can continue to receive necessary VA care while engaging in training or employment activities.

Based on the Legion/VA cooperative program to assist homeless veterans heretofore described, we fully support an expansion of the CWT program as proposed in this legislation. Section 6 of this bill would amend Chapter 73 of title 38, United States Code, to establish "Subchapter VII-Nonprofit Corporations for Veterans Compensated Work Therapy Programs."

This subchapter would authorize the Secretary to establish one or more nonprofit corporations to provide a flexible funding mechanism for the conduct of Department compensated work therapy programs for veterans (including homeless veterans) in such community(s) as the Secretary may designate.

It would also enable such nonprofit corporation(s) to accept gifts and grants which would be transferred to the STRAF account thereby enabling VA to purchase homes and administer the CWT and Transitional Housing Program.

Overall supervision of the corporation would be provided through a board of directors consisting of VA and community representatives who will serve as liaisons with the community, VA, and the nonprofit corporation. The Secretary of Veterans Affairs shall submit annual reports on the number and location of corporations established and the amount of contributions made to each corporation to the Congressional Committees on Veterans Affairs. The authority to establish such nonprofit corporations would expire on September 30, 1992.

The proposed establishment of nonprofit corporations is one of three key program models which this bill hopes to establish. As we understand the intent of this legislation, up to 18 pilot sites of transitional housing are to be approved utilizing three programs models: (1) purchased housing; (2) nonprofit corporation assistance; and, (3) using existing space within VA medical centers. All of these sheltered environments will be evaluated to determine the most effective program model, both from a therapeutic as well as an economic standpoint.

The American Legion would offer no objection to this proposal.

Section 7 of the bill addresses the use of funds available for the pilot program of community-based care for homeless, chronically mentally ill and other veterans.

It would require the Secretary to transfer a minimum of $1.625 million, and up to $5 million, to the STRAF account from those monies currently set aside for the HCMI program, to establish the mechanism to begin purchasing homes for therapeutic residences. Such funds could be used without regard to fiscal year limitation. According to VA, the $1.625 million to be set aside for the pilot program represents the minimum amount of resources necessary to integrate the CWT-HCMI programs.

Mr. Chairman, the ultimate goal of this legislation is to enhance the Department's efforts to assist homeless veterans in acquiring the job skills necessary to live productive and complete lives. It represents an innovative approach to the development of therapeutic and rehabilitative services to include transitional housing, through the Compensated Work Therapy Program.

We believe the proposed pilot program deserves an opportunity to demonstrate the effectiveness of integrating these two successful assistance programs.

Mr. Chairman, that concludes our statement.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

STATEMENT OF

DENNIS M. CULLINAN, ASSISTANT DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

WITH RESPECT TO

MENTAL HEALTH AND OTHER HEALTH CARE RELATED LEGISLATION

WASHINGTON, D. C. JUNE 14, 1989

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

On behalf of the 2.2 million members of the Veterans of Foreign Wars of the United States, I wish to thank you for affording us this opportunity to present our views with respect to legislation affecting mental health care provided to this nation's veterans by the Department of Veterans Affairs as well as other health care related legislative initiatives. Given that a significant number of this nation's homeless are veterans who are suffering from posttraumatic stress disorder (PTSD) as well as other mental disabilities incidental to their service in the United States Armed Forces, the VFW commends the Chairman and members of this Committee for holding this hearing today which is directed toward alleviating their suffering. Although the wounds of these brave men and women may not be physically apparent, the pain is nonetheless real and they certainly deserve all the help a grateful nation can provide.

First under consideration today are a number of sections from a bill sponsored by the Chairman of this Committee, Senator Cranston, along with Senators Matsunaga, DeConcini, and Rockefeller, the "Veteran's Benefits and

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Health Care Act of 1989," **S. 13.** This bill's stated purpose is the provision of cost-of-living increases in certain benefits paid to veterans with service-connected disabilities and to certain dependents and survivors of such veterans and the continued maintenance and improvement of the VA programs of benefits and services for our nation's veterans and their dependents. Certain provisions of S. 13 are also intended to find ways to improve VA programs without incurring any significant new costs.

Section 201 of S. 13 requires the VA to furnish posttraumatic stress disorder treatment to a veteran who served in a theater of combat operations and whom a VA mental health professional has diagnosed as suffering from service related PTSD. The VFW supports this provision in light of the fact that current budget shortfalls suffered by the VA has produced a situation where veterans with combat related PTSD may well be turned away from treatment at VA medical centers. Often times a veteran's symptoms are not sufficiently overt to allow for a ready diagnosis of PTSD with a consequent determination of service connected. As VAMCs struggle to contend with their budgetary shortfalls, veterans who are not recognized as category "A" are more likely than ever to be refused desperately needed care or must wait an inordinate amount of time before receiving such care. In December of last year the Research Triangle Institute (RTI) released its final report which indicates that the number of veterans currently suffering from full blown cases of PTSD and those with PTSD symptoms which adversely affect their lives but whose symptoms are not of the intensity required for a diagnosis of PTSD is alarming, approxiamately 829,000 of the 3.14 million veterans who served in Vietnam. Further a substantial number of these veterans have yet to receive any mental health help whatsoever. Even though the majority of Vietnam veterans have adjusted well to civilian life, there are still a substantial number who have not been able to come home from the war and these service-connected disabled veterans truly need and deserve our help. It is the VFW's long held conviction that the VA should be the leader in the diagnosis and treatment of PTSD and other service-connected mental disorders afflicting veterans, especially Vietnam veterans.

Section 202 would mandate that the VA's Special Committee on posttraumatic stress disorder submit concurrently to the VA and the two congressional Veterans' Affairs Committees through three reports--the first due June 1, 1989, giving the Special Committee's evaluation of the results of the study mandated by PL 98-160 on the prevalence and incidence of PTSD among Vietnam veterans, and the second and third reports due February 1 of 1991 and 1992, respectively updating prior reviews of the VA's efforts to meet the needs of veterans with PTSD. In light of the important role this Special Committee has played with regard to identifying problems and solutions, the VFW concurs that the reporting requirements of this Committee should be extended and therefore we strongly supports this section.

Section 203 of S. 13 would require the VA to carry out a scientifically valid study of post-war psychological problems--including PTSD--among Asian American, American Indian, native-Hawiian, other native-American Pacific Islanders, and Alaska-native Vietnam veterans. Since these various ethnic groups exist in small numbers in the general population of Vietnam veterans, over sampling, studying a proportionately higher number than for veterans in general, would be required to derive an estimate of the prevalence of PTSD and other post-war psychological problems in the readjustment to civilian life for members of these groups. In light of this fact and that the Research Triangle Institute study did over sample the racial/ethnic groups of blacks and hispanics in its PTSD study in order to arrive at valid conclusions for these groups, the VFW supports section 203 which would afford the same statistical treatment to these other groups.

Section 204 of this legislation requires the VA to submit as part of its annual budget documents detailed information on funds that are estimated to be spent for compensation for PTSD, PTSD treatment and other PTSD related VA efforts. The VFW believes that it is well advised to require the VA to focus in this manner on its allocation of resources to PTSD related activities and should help the department make more adequate provision for meeting the needs of veterans who due to the combat related nature of their illness are so deserving of help on a priority basis. The VFW supports this section.

Section 221 of S. 13(a) would require that the Assistant Secretary of Veterans Affairs who is responsible for management, productivity and logistic support functions be responsible for the technical and functional supervision--but not the day to day supervision or line management--of security services at VA medical facilities. In this regard, the VFW has testified in the past with respect to the serious problems in recruitment, retention and training of appropriately qualified individuals for the VA security service. VA security service is responsible for protection of both the patients and staff at VA medical centers which, of course, impacts the ability of these facilities to furnish high quality care to this nation's veterans. Furthermore, the VA security service staff serves as an important intermediary between the general public and the VA health care service. We have repeatedly articulated the need for a higher quality VA police force. This section is intended to facilitate the attainment of these goals by organizationally relocating the security service in the VA Central Office by moving it from the VHS & RA to an Assistant Secretary. This Assistant Secretary would be responsible for the functional and technical supervision of

VA police activities while the Medical Center Director would continue to provide day to day supervision of police officers at their facilities. Since this type of arrangement has worked adequately for fiscal and supply/procurement functions for several years by focusing the efforts of the Chief Medical Director on policy issues most directly related to the furnishing of health care services, it may also prove to be effective for security functions as well. In light of the very apparent need to improve the VA security service, the VFW would not oppose part "(a)" of section 221.

Section 221(b) would require the VA within 90 days after enactment to submit a report containing:

(1) A plan for upgrading its security, police training, recruitment and salaries; and

(2) an evaluation of the need for:

- a establishing a policy on weapons for the VAMCs in high crime areas, and
- b reducing VA security police services in certain VA facilities with no significant security problems

The VFW views the proposed report as a viable means of facilitating the upgrading of the VA security service with respect to training, recruitment and salaries. As has already been mentioned, the VFW has strongly supported enhancing these areas in the past. The VFW has also testified with respect to a policy on weapons for VAMCs in high crime areas. Our contention was and remains that VA security police operating in high crime areas should be allowed to carry weapons in certain circumstances when patrolling outside of such a VAMC. We do not support armed security personnel within the VAMC, but only in areas outside of the medical center and at entrances and exits. We also point out that it is absolutely essential that where weapons are involved that the security police only be of the highest caliber and have undergone extensive training.

With respect to reducing VA security police services in facilities with no significant security problems, we must express some concern. To begin, it is hard to imagine that there are any VA medical centers without any security problems and even in rural areas where security requirements are minimal, we would not wish to see such facilities left defenseless, bereft of all security protection. Thus, even though we condone the allocation of security staff according to need, we would not wish to see any medical center left unprotected.

We will now address an amendment to section 212 of S. 13 which is to be offered by Senator Cranston, Chairman of this Committee. This amendment would establish a 5 year pilot program to expand and enhance VA Compensated Work Therapy (CWT) programs. This pilot program would provide for testing at up to 25 sites, an innovative approach to providing veteran patients--primarily those recovering from mental disabilities or drug or alcohol conditions--with the services to help them make the transition from inpatient care to independent living in the community. Under the pilot program VA would help to create nonprofit corporations with which it would contract to conduct CWT programs--structure job opportunities, under section 1618 of title 38, arranged under contract with private businesses--and to which it could make loans to facilitate the corporations setting up Therapeutic Residences (TRs) providing relatively independent group living arrangements. In order to be eligible to receive a CWT contract under this program, the corporation would have to run a TR. The CWT/TR programs would provide work therapy during the day and supervised living experience at night.

Compensated Work Therapy programs provide at a low cost to government numerous theraputic benefits to VA patients in a work setting. CWT programs involve the use of work subcontracting paid for by businesses with wages generated through the work contracts and generally paid on piecework bases. The jobs vary greatly from simple packaging to fabrication and assembly operations using complex machinery and take place in VA medical centers in the community or on industrial sites. Not only do these programs provide a clincial procedure for evaluating the patient's vocational or avocational interests, attitudes and skills, but they also provide a method for assessing the patient's physical and mental capacities for work in actual situations. CWT programs also encourage the development of good work habits by emphasizing attendance, reliability, punctuality, productivity, craftsmanship and personal responsibility. Individuals working in CWT programs gain a sense of being productive while developing important work skills. Accordingly the VFW supports this amendment to section 212 of S. 13 which provides for a pilot program to help create non-profit corporations which would conduct CWT/TR programs.

Next under consideration today is **S. 192**, a bill sponsored by Senator Matsunaga of this Committee along with Senators Inouye and Cranston, which would require the Secretary of Veterans Affairs to provide for the conduct of the comprehensive study of the physchological problems of native Americans who are Vietnam veterans. Our support of this worthy legislative initiative is, of course, in keeping with our already articulated support of section 203 of S. 13, which requires a similar psychological evaluation of ethnic groups referrenced in both bills.

The next bill which we will address is **S. 846** introduced by Senator Murkowski, the Ranking Minority Member of this Committee, which would amend title 38, United States Code to improve the Compensated Work Therapy and other services and assistance furnished to homeless veterans and other veterans. This legislation would extend VA's authority for 5 years through September 30, 1994, to provide care and treatment in halfway houses for homeless veterans with chronic mental illnesses, authorize VA to contract with itself or other government agencies or departments to provide therapeutic work for VA patients, authorize VA to establish transitional housing for veterans participating in the Compensated Work Therapy program, permit VA to purchase lease or otherwise acquire houses to be operated by VA as transitional housing for veterans who are participating in the CWT program, authorize VA to establish nonprofit corporations to provide a flexible funding mechanism for the conduct of CWT programs and, lastly, would require VA to transfer approximately $1.6 million and authorize a transfer of up to $5 million to the Special Therapeutic and Rehabilitation Activities Fund (STRAF) from funds appropriated for the conduct of the Homeless Chronically Mentally Ill program. In this regard, the VFW has earlier today voiced its support of Senator Cranston's proposed amendment to section 212 of S. 13 which would establish a 5 year pilot program to expand and enhance VA Compensated Work Therapy programs. These two legislative initiatives are similar in intent, we view the particulars of their provisions as being complimentary and should serve to augment one another. We view S. 846 as being a highly innovative and well crafted legislative initiative which could significantly improve the Department of Veterans Affairs programs which assist homeless veterans and other veterans. This bill enjoys VFW support and we commend Senator Murkowski for its introduction.

Next under consideration today is S. 86 a bill sponsored by Senator Cranston along with Senators Murkowski, Matsunaga, DeConcini, Rockefeller and

Gramm. A bill to amend title 38, United States Code to improve the capability of the Department of Veterans Affairs health care facilities to provide the most effective and appropriate services possible to veterans suffering from mental illnesses. This pertains especially to conditions which are service related through the designation of up to five of its facilities as centers of mental illness research, education, clinical activities and for other purposes. This legislation would specifically authorize the establishment of five Mental Illness Research, Education, and Clinical Centers (MIRECCs) that would be modeled after the VA's very successful Geriatric Research, Education and Clinical Centers (GRECCs). These facilities would serve as centers of excellence for mental illness treatment, research and education. It is intended that each MIRECC would bring together an effective body of investigators with a clear and focused clinical research mission concentrating on one or more of the major categories of illness from which veterans suffer such as schizophrenia, PTSD, addictive disorders, depressive neuroses or dementia. The bill would require that research projects undertaken in conjunction with the MIRECC mission emphasize phychosocial and clinical aspects of mental illness, as well as models of providing services. In light of the tremendous unmet need with respect to servicing the mental health care needs of this nation's Vietnam and other veterans, the VFW strongly supports the implementation of this proposal so that our nation's veterans suffering from service-connected mental disorders may be provided with the most effective and appropriate services possible.

Last under discussion today is S. 405 a bill sponsored by Chairman Cranston together with Senators DeConcini and Matsunaga which would amend title 38, United States Code to require the Department of Veterans Affairs to conduct a program providing community based residential treatment for homeless chronically mentally ill veterans and to authorize the inclusion of certain other chronically mentally ill veterans in such programs and for other purposes. This bill would in effect provide for a 3 year extention in the VA's highly successful Homeless Chronically Mentally Ill (HCMI) program by codifing the program in title 38 of the United States Code and removing its designation as a pilot program.

The suffering of this nation's homeless veterans is a terrible blight on our national character. Various surveys place the prcentage of veterans in the homeless population between 18 and 51 percent. Using these estimates between 135,500-382,000 veterans, many of whom are chronically mentally ill, are currently homeless. The HCMI program which is a community based program for homeless chronically mentally ill veterans combines aggressive outreach with health care services, intensive case management and time limited care in non-VA residential treatment centers. They have thus far proven to be highly effective and the VFW supports its continuation. The VFW strongly commends the introduction of S. 405.

Mr. Chairman, this concludes my statement. I wish to thank you and the other members of this Committee for conducting this hearing today which addresses the needs of a highly deserving and vulnerable component of the veteran population. Again thank you, and I will be happy to respond to any questions you may have.

PVA
PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

STATEMENT OF

FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

SENATE COMMITTEE ON VETERANS' AFFAIRS

CONCERNING

LEGISLATION TO IMPROVE VA MENTAL HEALTH PROGRAMS AND VA
HEALTH SERVICES - -
INCLUDING: SECTIONS 201, 202, 203, 204, AND 221 OF S. 13 -
"THE VETERANS BENEFITS AND HEALTH CARE ACT OF 1989," WITH AN
AMENDMENT THERETO; AND, S. 192, S. 846, S. 86, AND S. 405.

June 14, 1989

Mr. Chairman, and Members of the Committee, on behalf of the members of Paralyzed Veterans of America (PVA) I want to thank you for the opportunity to present our views on legislation designed to improve the Department of Veterans Affairs' (DVA) mental health programs. As requested, I would also like to comment on section 221 of S. 13 which would reorganize, and provide a vehicle to improve, the function of DVA security personnel.

The Department of Veterans Affairs plays a major national role in the provision of mental health services and research. According to the National

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Institutes of Mental Health, 51 percent of all veterans in need of mental health services receive that care through the Department. In 1988, the DVA provided care to 285,562 veterans with mental disorders amounting to 45.6 percent of all individual patients seen in the system. Mental health services generated 4,061,288 outpatient visits or 18.9 percent of all outpatient visits provided by the Department. Public and private mental health providers in the United States could not begin to accept this patient load if the DVA was not able to sustain the operation of its mental health programs.

Mr. Chairman, as this hearing again today indicates, your deep concern over the years for the needs of veterans suffering mental health disorders has brought the DVA a long way in being more responsive to those needs. We are pleased to comment on the legislative proposals before us today that recommend additional improvements to this important health care function.

S. 13

Veterans Benefits and Health Care Act of 1989

Section 201. "Care For Combat Veterans With Service-Related Post-Traumatic Stress Disorder"

This provision would provide priority inpatient and outpatient mental health services for any veteran suffering from diagnosed post-traumatic stress disorder who participated in hostilities in World War I, World War II, Korea, Vietnam, or subsequent armed hostilities and military actions. Consistent with our previous positions, Paralyzed Veterans of America strongly supports this provision.

The Department has become a leader in the diagnosis and treatment of Post-Traumatic Stress Disorder (PTSD). The leadership demonstrated by this Committee in helping to design, authorize and expand treatment and research in PTSD programs for Vietnam veterans has fostered a credible body of knowledge that has benefited thousands of Americans, veteran and non-veteran alike, who suffer from this disabling disorder. For this reason, it has become increasing clear that PTSD, while having certain manifestations unique to the Vietnam veteran, is not solely limited to that population. Individuals who experience the intense stress of combat situations can and do reveal PTSD symptoms years, even decades, later.

At the present time, the DVA is curtailing the availability of both inpatient and outpatient services for thousands of veterans - veterans in need of a wide variety of health care services - due the persistent funding shortfall facing the Department. Many of these veterans fall into Category B and Category C eligibility criteria. However, as we have testified previously, the DVA is also delaying and denying treatment for Category A veterans in need of both inpatient and outpatient services. We have sought to at least partially correct this situation by calling for a clear mandatory entitlement for outpatient services for all Category A veterans. We urge the Committee to, once again, review and adopt this proposal. However, at the same time, we enthusiastically endorse this section of S. 13 which would, at least, create a clear entitlement for mental health treatment for all veterans suffering from this individual disorder, PTSD.

Section 202. "Special Committee on Post-Traumatic Stress Disorder"

This section would require the VA's Special Committee on Post-Traumatic Stress Disorder to submit to the Secretary and the Congress its findings and recommendations from a review of the "National Vietnam Veterans Readjustment Study" on how to enhance readjustment programs for Vietnam veterans. The provision would also require the Committee to continue to report and make recommendations utilizing its previous mission to analyze and report on the status of these programs, as well, on an ongoing basis. PVA has always found the Special Committee on Post-Traumatic Stress Disorder to be an important stimulus and an effective advocate for the Department's PTSD programs and services. We support enactment of this provision.

Section 203 "Study of Psychological Problems Among Asian-American, American-Indian, Native Hawaiian, Other Native-American Pacific Islander (Including American Samoan Native), and Alaska Native Vietnam Veterans."

This provision is identical to the language of S. 192 introduced by Senator Matsunaga. PVA greatly appreciates the concerns expressed by the Senator in drafting this bill and bringing this matter to the attention of the Committee. PVA, too, is concerned that the "National Vietnam Veterans Readjustment Study" authorized by P.L. 98-528 did not specifically address the readjustment status of native Americans in the Continental United States, Alaska, Hawaii and the Pacific Islands. The study did, however, reveal that veterans in all minority groups continue to suffer readjustment problems in higher degrees than their veteran counterparts in the rest of the Vietnam veteran population. From what we understand from anecdotal evidence, this finding can also be extrapolated to the populations that are identified in this provision.

The DVA should move immediately to address this problem. A study in the nature of the proposal contained in this Section and in S. 192 could provide important corroborative data. However, we understand the approximate cost of conducting such a study would be in excess of $1 million and would take at least one year, if not two to three years to design, implement and evaluate. We believe that the investment placed in this study, both in manpower time and dollars, could be far better expended in providing immediate and direct services to meet the needs of this veteran population. We also believe that important statistical information on the readjustment status of these veterans could be derived from the patient treatment files once additional outreach, counseling and services were provided to these patient populations. At the same time, these veterans would be receiving more immediate assistance now, rather than having to wait until the proposed study itself is completed later.

Section 204 "Funding For Post Traumatic Stress Disorder Programs"

This provision would require the Department, when submitting its annual budget documents to the Congress, to identify the amounts to be obligated in the upcoming fiscal year for compensation to and treatment of veterans with

PTSD. PVA finds this to be a valuable exercise to assist the Congress in monitoring the extent of PTSD within the veteran population and the adequacy of the DVA's response in addressing the needs of these veterans.

Section 212 "Security and Law Enforcement Functions"

This provision would transfer the functional authority, direction, and control of the DVA Security forces from the Chief Medical Director and the Chief Benefits Director to the newly established Assistant Secretary for Management, Productivity and Logistics. Section (b) of the provision would also require the Secretary of Veterans Affairs to submit a report to Congress with his recommendations for improving the training, recruitment and pay of security and law enforcement personnel of the DVA; his assessment of the needs for establishing a policy on the issuance of weapons to certain security personnel; and his findings on the advisability of reorganizing the stationing of DVA security forces, transferring positions from stations that do not have significant security problems to those stations that have a higher incident rate.

PVA has long been concerned that the Department should improve the quality and operation of its security personnel. A quality VA security force must be able to recruit and retain properly motivated and qualified individuals.

These individuals must receive adequate on-going training and supervision to meet unique security functions that vary from station to station.

Security activities are an integral part of the operation of any VA station, but particularly VA medical centers. Within that function, security forces must serve to protect the veteran patients and VA staff. They must also coordinate with community government and law enforcement entities. As such, we believe that administrative responsibility and supervisions of VA security staff should remain under the direct control of the individual departments for which they serve. The Veterans Health Services and Research Administration, for instance, and the individual medical center directors should maintain specific jurisdiction and authority over the personnel who maintain order in their own facilities.

This is not to say that more immediate attention should not be taken by the Chief Medical Director and the Chief Benefits Director to provide a thorough review of security personnel activities. For this reason, PVA supports paragraph (b)(1) of this section which calls on the Secretary to submit a plan for improving the training, recruitment and pay of security and law enforcement personnel of the DVA.

Paragraph (b)(2)(A) calls on the Secretary to assess the need for establishing a policy on the issuance of weapons to security personnel assigned to medical centers in high crime areas. PVA recommends that the Secretary proceed with extreme caution in formulating this assessment, carefully weighing the potential benefits, but also the inherent dangers in allowing security personnel to carry any weapon or sidearm in any health care facility.

Paragraph (b)(2)(B) asks the Secretary to rule on the advisability of reorganizing and reassigning VA security personnel, transferring personnel resources from facilities that do not have significant security problems in order to increase services at facilities with more significant problems. PVA concurs that this would be an efficient move as long as the analysis is properly conducted to insure that adequate security is maintained at all stations.

S.86 "Mental Illness Research, Education, And Clinical Centers"

This legislation would establish not more than five (and at least one before July 1, 1990) Mental Illness Research, Education, and Clinical Centers (MIRECCS) to act as centers of excellence in the study and treatment of mental illness. Noting the size and composition of the DVA's mental health mission, PVA believes this to be an admirable proposal which could significantly improve the Department's health care mission and reputation. Concentrated applied research and education in mental health science can only provide significant improvements in care for the veteran patient and in the advancement of health science as a whole.

We understand that the MIRECC program is patterned after the highly successful Geriatric Research Education and Clinical Center (GRECC) concept in adapting the model currently functioning to coordinate geriatric research operations to the field of mental health science. Cost estimates, too, are derived from the GRECC experience: $3.125 million to establish all five MIRECCS the first year and $6.25 million to operate the five centers for each of the next three years. PVA is not certain where these dollars will come from at a time when the Department does not have the resources to maintain the operation of all existing authorized programs within its jurisdiction. We are specifically concerned that the Congress has authorized the VA to establish 25 GRECCS, and because of chronic funding shortfalls over the past several years the DVA has only managed to open and operate 10 of these centers.

As we have testified in the past, of immediate concern to our membership is the need for the Department to designate one existing GRECC to have a clinical research and education specialty in aging with a spinal cord or other catastrophic disability. This Committee last year underscored the need for this relatively modest proposal in its budget views and estimates for FY 1989. Subsequently, the Chief Medical Director informed PVA last year that he had approved the proposal and efforts were underway to select the appropriate site for this program. However, to date, largely, we imagine because of the acute funding problems within the Department, this project has stalled.

As we stated previously, PVA finds the MIRECC concept laudable. However, we would suggest that prior to authorization and implementation of this program, the Committee make certain that all preexisting funding commitments to similarly functioning research and education programs, including the so-called "SCI GRECC", are fully met.

S. 405 Homeless Chronically Mentally Ill Program, S. 846, sec. 3

Both S. 405 introduced by Senator Cranston and section 3 of S. 846, introduced by Senator Murkowski would extend the Department's program for the care and treatment of homeless chronically mentally ill veterans. PVA has found this program to be an effective tool in meeting the chronic health care and support needs of this population. With current statistics showing that up to 40 percent of homeless males are veterans, the DVA has a very straightforward and immediate mission in this area.

S. 405 would change the designation of the program from a pilot status to a standard operating program. The bill would extend the authorization for the program for an additional three years or until September 30, 1992. Section 3 of S. 846 would maintain the program as a pilot but extend its operation for five years or until 1994.

PVA understands that the pilot status of the program is currently of concern to many of the dedicated personnel providing these services for homeless veterans. Pilot status does not insure employment stability and the option of career status within the DVA as would happen if the program were to be made permanent. PVA believes that the HCMI program has proven to provide an effective and needed service. The pilot status should be removed in order to give the Department the further ability to recruit and retain these very specialized and dedicated personnel In the spirit of compromise, we might suggest that pilot status be removed as in Senator Cranston's legislation and that authorization for the program be extended for four years rather than the three years called for in the Chairman's bill and the five years provided for in Senator Murkowski's legislation.

Compensated Work Therapy Program

Cranston Amendment To Section 212 of S. 13

S. 846 Sections 4, 5, 6, 7, and 8

Compensated work therapy programs have been of great value in the institutional setting to provide activities involving occupational goals matched with compensation incentives as part of the rehabilitation process for certain seriously disabled veterans primarily recovering from mental disabilities or drug or alcohol dependency. Both Senator Murkowski's bill, S. 846 and Senator Cranston's amendment would expand this concept to provide post-discharge compensated work therapy programs coupled with supervised housing or therapeutic residences to assist in the veteran's transition from the institutional setting to society at large. We have found that, when properly monitored and supervised, this "half-way house" approach to transitioning, coupled with a quality work therapy program can be very useful in extending the "arm" or influence of the institutional therapy program into the community, while at the same time, "easing" the disabled veteran back into society equipped with the confidence and skills to eventually cope more independently with activities of daily living.

Senator Cranston's amendment would authorize a five-year pilot program of compensated work therapy programs in conjunction with therapeutic residences at 25 sites. The Department would establish the entire program by entering into agreements with, and providing loans to, non-profit organizations that would operate and conduct both residential supervision and work therapy programs for these veterans. Senator Murkowski's legislation, also utilizes this non-profit approach, but also authorizes the DVA to contract directly with community entities for these services or to lease space to operate these programs on their own.

PVA believes that both approaches could be useful to give the Department the opportunity and the flexibility to establish programs that could meet both the immediate needs of veteran patients and the availability of existing or potential community and DVA resources that undoubtedly vary greatly from one VA medical center location to another.

Mr. Chairman, this concludes our testimony, I will be happy to repond to any questions you might have.

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STATEMENT OF

VIETNAM VETERANS OF AMERICA, INC.

Presented By

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before the

SENATE COMMITTEE ON VETERANS AFFAIRS

on

MENTAL HEALTH CARE LEGISLATION

JUNE 14, 1989

Mr. Chairman and members of the Committee, the Vietnam Veterans of America (VVA) appreciates this opportunity to present its views on some of the issues in Mental Health which effect veterans. In addition to the legislative proposals we have reviewed for this hearing, we will offer additional recommendations on the subject.

Regarding S.13, section 201: Care For Combat Veterans With Service-Related Post -Traumatic Stress Disorder, VVA is strongly supportive of this initiative. It is appropriate to grant presumptive status for health care to those veterans who served on active duty in a theater of combat operations in all wars or conflicts during a period in which hostilities occurred and for which PTSD is diagnosed.

Further, for all veterans so diagnosed and thereby made eligible for health care by this Bill, a determination of service-connection for purposes of benefits entitlements should also be presumptive.

Regarding S.13, section 202: Special Committee On Post-Traumatic Stress Disorder, VVA supports this Bill. The Chief Medical Director's Special Committee On Post-Traumatic Stress Disorder in all of their Annual Reports have made numerous recommendation to which the DVA has either minimally responded or simply not followed up. There is a clear need for the DVA to revisit these reports and their recommendations in light of the recognition by many that the mental health needs of the mentally disabled veteran are not being met on many levels, on many fronts, in many ways.

Regarding S.13, section 203, it is addressed in S.192 below.

Regarding S.13, section 204: Funding For Post-Traumatic Stress Disorder Programs, VVA recognizes the need to hold the DVA accountable for PTSD care in terms of tracking its expenditures for such programs. We are aware that DVA has cut its contractual services budget by one half or as much as 2.5 million dollars in an attempt to protect in-hospital PTSD operations. Such cuts, sometimes made with little warning to community providers of service has in many cases completely interfered with the continuity of services to veterans in addition to completely ruining all credibility and trust these community providers of service may have for the DVA and the American government.

Additionally, some of these vendors, out of compassion for the veteran, had continued to provide services to the veteran at their own expense. Surely our veterans deserve better treatment than this! VVA supports this Bill for reasons of getting the DVA to be more accountable for its actions in the PTSD arena, and because of the need to revisit its own Special Committee On Post-Traumatic Stress Disorder recommendations which we believe, if implemented, will go a long way to resolve some of the mental health care problems the DVA needs to resolve. With regard to the National Center on Post-Traumatic Stress Disorder established under section 110(c) of Public Law 98-528; since the dissolution of the Center in Cleveland, Ohio, it is our recommendation that the Center, wherever it is to be located, goes on line as soon as possible.

Regarding S.13, section 221: Security Services, the need for establishing a policy on the issuance of weapons (particularly fire arms) to security personnel assigned to medical centers in the Department located in high crime areas, and the use of such weapons by such personnel is a matter of great concern. At this time, VVA discourages the use and carrying of fire arms in medical centers by DVA security personnel. Besides the fact it sends a message of separation - "it's them versus me," rather than that the Officer is a friend and team member, there have been, according to some of the incidents at some medical centers, indications that some staff may actually use the weapon rather than resort to the many behavioral options available to him/her via education, training, experience, effective communication systems, utilization of other staff, policies and procedures, effective client screening, orientation and communication, and the opportunity to use community security personnel. Truly, this is a subject that requires close review. We support this Bill on that issue alone.

Regarding S.86 which would provide for the designation of up to five of its facilities as centers of mental illness research, education, and clinical activities (MIRECCs) and for other purposes, VVA offers the following comments.

The DVA established ten so-called "super Veteran Out Reach Centers," i.e., Resource Centers. Such a Center is based at the Brooklyn, New York Veterans Administration Medical Center. These centers, in part, were to provide multiple services such as readjustment counseling, vocational, educational and veterans benefit services all under one roof so to speak. Review of these Centers indicate that for the most part, they are underfunded, undermanned, and without the necessary collateral support systems relative to the medical centers and the Department of Veteran Benefits to facilitate their success in service to veterans.

VVA supports the concept of MIRECCs but with the expectation that they will be fully supported in terms of staff, resources, collateral systems, medical center and Department of Veteran Benefits support. These Centers like the GRECC's, should be affiliated with appropriate schools of medicine and other allied professional institutions involved in mental health. However, these affiliations must be driven primarily by the veterans clinical needs followed and supported by the need of staff for research and educational activities in the client's clinical interest.

Regarding S.192 to require the Secretary of Veteran' Affairs to provide for the conduct of a comprehensive study of the psychological problems of Native Americans who are Vietnam veterans, VVA notes that the Research Triangle Institute's National Vietnam Veterans Readjustment Study is not adequate in addressing the issue of psychological problems among Asian-American, Native-American, Native-Hawaiian, other native-American pacific islander (including American Samoan native), and Alaska native Vietnam Veterans. Therefore, VVA supports this legislative initiative.

Regarding S.405 to require the Department of Veterans' Affairs (DVA) to conduct a program providing community-based residential treatment for homeless chronically mentally veterans and to authorize the inclusion of certain other chronically mentally ill veterans in such a program, and for other purposes, VVA compliments the authors of this legislative initiative. We recognize the importance of developing clinical strategies in the care of the mentally impaired which moves away from inappropriate institutionalization and closed-ward settings towards community-based programs which offers the veteran, at an appropriate resource utilization level, increased opportunities to heal in more natural environments.

It is our sincere hope, as we strongly support this proposal, that the DVA will finally allocate resources for mental health services based on the percentage of resources mental health utilizes. It has been pointed out by many including VVA in previous testimony that mental health services are not proportionately represented in the total health care budget relative to the amount of mental health services DVA provides.

We have in previous testimony recommended that in accordance with the three Annual Reports of the Chief Medical Director's Special Committee on Post-Traumatic Stress Disorder a special diagnostic related grouping (DRG) be assigned for inpatient treatment of PTSD. The rationale for this recommendation still stands solid. Realistic costs should be determined for mental health delivery based on the realistic resource needs generated by the great diagnostic diversity and patient care requirements that, in fact, occurs in the DVA mental health care setting.

Regarding S.846, to improve the compensated work therapy and other services and assistance furnished to homeless veterans and other veterans, VVA supports section 3, namely, the extension of the pilot program of community-based care for homeless chronically mentally ill and other veterans to 1994.

Regarding the legislative proposals for section 4 of S.846, Expansion Of Compensated Work Therapy Program, if "members in Department health care facilities" in addition to "patients" refers to eligible veterans, then VVA supports this initiative. We also support section 5, Compensated Work Therapy Communities, the establishment and operation of therapeutic and rehabilitative activities transitional housing for eligible veterans.

Section 7 of S.846, pertaining to transfer of funds of $1,625,000 up to $5,000,000 out of appropriated funds to the Special Therapeutic and Rehabilitation Activities Fund is in itself a special issue. If these funds ultimately come from current actual and authorized dollars for current mental health programs which are already underfunded partly because mental health has not received its fair share of the health budget, health care availability for the mentally disabled will suffer even more.

The remainder of this testimony will speak briefly to three issues. First, it is clearly apparent that there is a need to place the (Department of) Veterans Affairs Advisory Committee on the Readjustment of Vietnam Veterans in permanent statute. This Committee in the performance of its many duties including program analysis and surveillance, making important recommendations to the field on issues of readjustment, site visitations, and issues review, puts forth a vital service for the Secretary, the DVA mental health delivery system, and most of all, for not just the Vietnam veteran but all veterans by its participation in moving the system towards assuring a quality mental health care product.

Secondly, I would draw this Committee's attention to the VVA's May 3, 1989 statement on Incarcerated Veterans before the House Veterans Affairs Subcommittee on Oversight and Investigation. In seeking your attention regarding this statement, we would note a guiding principle namely, that when these veterans served their country, the services and benefits they earned were not contingent upon anything but this country's decision to extend them a debt of gratitude for a job for which it was determined by this government had to be done.

Thirdly, we need to be assured that the issue of dual diagnosis continues to be addressed. I would refer you to the March 16, 1989 VVA statement before this Committee on the DVA health care system in which it is pointed out in recommendation number nine which states in part: "As an example, the DVA treats alcoholism, drug addiction, and PTSD in many of its facilities as separate non-interactional clinical maladies. Treatment for each is provided under separate programs, separate budgets, separate staffs, separate ideological rationales and separate medical school affiliate interests. This approach is not only very costly but may not be in the best clinical interest of the veteran being treated in many instances. The veteran whose substance abuse problems are a component of his or her PTSD is a classic example. Under the circumstances, both the substance abuse and PTSD problems must be treated together."

There are several other recommendations which VVA has made which are not addressed in any of the legislation being considered today but which bear directly on the issues of mental health care for veterans.

In light of the results of the Research Triangle Study it is apparent that the incidence of symptoms of Post Traumatic Stress Disorder is of epidemic proportions yet this information has not led to legislative or administrative decisions consistent with the findings of that study. VVA recommends that the Vet Center and in-patient PTSD Programs be expanded. We also recommend that research programs be undertaken to determine the most appropriate treatment modalities for Post Traumatic Stress Disorder and that a scholarship program to train mental health care professionals in treatment of PTSD and other war related psychological disabilities be undertaken and modeled on the nurse scholarship program.

Finally, please allow me to close with the following comment. Mr. Jere A. Beery, USN/Ret. and a Vietnam veteran who has distinguished himself in service to this country asks this question: "Why is it an American citizen can go to a store front vision center and after eye exams, receive a pair of eye glasses in hand in one hour and a veteran cannot get a pair in the DVA for over six months after in some cases waiting more than weeks to get an eye exam?"

It seems to be a matter of the DVA being simply too massive and too centralized to deliver a good health care product to the veteran. This problem extends to DVA mental health care delivery as well, again citing the above horrible experience in which DVA health care system fails in fulfilling some of its contractual obligations to local mental health professionals providing readjustment services to veterans who have little opportunity to use other than these services. Again, citing the March 16, 1989 testimony before this Committee, "The entire mental health delivery system of the DVA should be reviewed in terms of program needs, availability, resource requirements and dedication, clinical and administrative organization and program priorities in view of budget constraints and competition with non-psychiatric programs." It appears the time has arrived, especially in view of the new department status the VA has achieved for a full Commission to be established to review the entire DVA health care delivery program.

VVA thanks you once again for the opportunity to address this Committee and express its views on DVA mental health care.